

6872

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>D. C.</b> c. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ralls Nursing Home</b>		d. STREET ADDRESS <b>1412 Delafield Pl, N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Sarah</b> Middle <b>L</b> Last <b>Alley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 16, 1884</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Dailey</b>		14. MOTHER'S MAIDEN NAME <b>Jane Albritton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0 Congestive Heart Failure</b> DUE TO (b) <b>Gen'l Arteriosclerosis</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Pulmonary Tuberculosis - healed</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar 22, 1959</b> , to <b>June 9, 1959</b> , that I last saw the deceased alive on <b>June 8, 1959</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Arthur H. Lewis</b>		DATE SIGNED <b>6/9/59</b>	
PHYSICIAN'S NAME (Type) <b>ARTHUR H. LEWIS, M.D.</b>		ADDRESS (Street, city or town, state) <b>1714 R St Ave NW Wash DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12 June '59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		24a. REC'D BY REGISTRAR <b>JUN 12 '59</b>	
ADDRESS <b>300 4th St. N. E.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. Lewis</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

44. SHOW LAB-PLUGS TO GET RUBBER CHAIR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6901

## CERTIFICATE OF DEATH

06864

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>149 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Tampa</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓ <b>48X-3</b> d. STREET ADDRESS <b>8503 Twin Lakes Boulevard</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Edgar Marshall Andrews, Jr.</b>				4. DATE OF DEATH Month Day Year <b>June 8, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 16, 1924</b>	
9. AGE (In years lost birthday) yrs. <b>34</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Company</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Edgar M. Andrews, Sr.</b>			
14. MOTHER'S MAIDEN NAME <b>Ebba Lundin</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WWII Unascertainable</b>			
16. SOCIAL SECURITY NO. <b>The Clinical Center, Bethesda 14, Maryland</b>				17. INFORMANT <b>The Medical Record</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Midline Lethal Granuloma</b> <b>138.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>January 10, 1959</b> , to <b>June 8, 1959</b> , that I last saw the deceased alive on <b>June 8, 1959</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 6-8-59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>							
ACTUAL SIGNATURE <b>James C. Kirby, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>James C. Kirby, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Bur. Trans.</b>		<b>Jne. 11, 1959</b>		<b>Tampa Cem.</b>		<b>Tampa, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

CERTIFICATE OF DEATH

1900

WEST VIRGINIA STATE DEPARTMENT OF HEALTH

1



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6902 Item 9 Film G244 6-30-59 et  
CERTIFICATE OF DEATH

06865

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Prince William</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(RURAL) Bethesda</b>		c. LENGTH OF STAY IN 1b <b>49 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bethesda, Md.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>(n)</b> Last <b>ARNOTT</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2 October 1898</b>
9. AGE (In years last birthday) yrs. <b>60 6/7</b>		IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Americal Supply Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>NEW JERSEY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert ARNOTT</b>		14. MOTHER'S MAIDEN NAME <b>Janet THOMSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW I WW II</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Mrs. Josephine ARNOTT</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Carcinomatosis</b> DUE TO (b) <b>(Adenocarcinoma, stomach with widespread metastases)</b> DUE TO (c) <b>(to liver, bone, lung)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-2</b> , 19 <b>59</b> , to <b>6-20</b> , 19 <b>59</b> that I last saw the deceased alive on <b>6-20</b> , 19 <b>59</b> , and that death occurred at <b>2320P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>F.H. O'CONNELL LT MC USN</b>		ADDRESS (Street, city or town, state) <b>U.S. NAVAL HOSPITAL BETHESDA MD</b> DATE SIGNED <b>6/21/59</b>	
PHYSICIAN'S NAME (Type) <b>F.H. O'CONNELL LT MC USN</b>		U.S. NAVAL HOSPITAL BETHESDA MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>CHAMBERS</b>		24a. REC'D BY REGISTRAR <b>JUN 23 59</b>	
ADDRESS <b>517 11th St S.E. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Frank</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06866

6903

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b> d. STREET ADDRESS <b>4422 South Dakota Ave. N.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>August</b> Last <b>Aue</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/91</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>7</b> Hours <b>15</b> Min.	11. IF UNDER 24 HRS. Hours <b>15</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Fred L. Aue</b>		14. MOTHER'S MAIDEN NAME <b>Marie Freund</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>578-07-7384</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PORTAL CIRRHOSIS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May</b> , 19 <b>51</b> , to <b>June 26</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 26</b> , 19 <b>59</b> , and that death occurred at <b>11:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stanley W. Kinsten</b> M.D.		ADDRESS (Street, city or town, state) <b>5910 Cambridge Ave. Wash. D.C.</b> DATE SIGNED <b>June 26 1959</b>	
PHYSICIAN'S NAME (Type) <b>STANLEY W. KINSTEN M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>6/29/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Washington, D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24a. REC'D BY REGISTRAR <b>JUN 29 1959</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6904 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06867

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
c. LENGTH OF STAY IN 1b <b>1 yr.</b>		d. STREET ADDRESS <b>7203 Denton Rd.,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Kensington Gardens</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>S.</b> Last <b>BABB</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26,</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1878</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR Months <b>1</b> Days <b>26</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>West Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Arnold Scherr</b>		14. MOTHER'S MAIDEN NAME <b>? Nichols</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Address</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>422.1</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (b) <b>Chronic Myocarditis</b> (c) <b>Chronic Myocarditis</b> DUE TO <b>Chronic Myocarditis</b> cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>Months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>None</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, 22b. DATE THEREOF <b>Burial-transit 6-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Queens Point Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Keyser, W. Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rbbert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 2 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>			

DATE SIGNED  
**June 26, 1959**

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

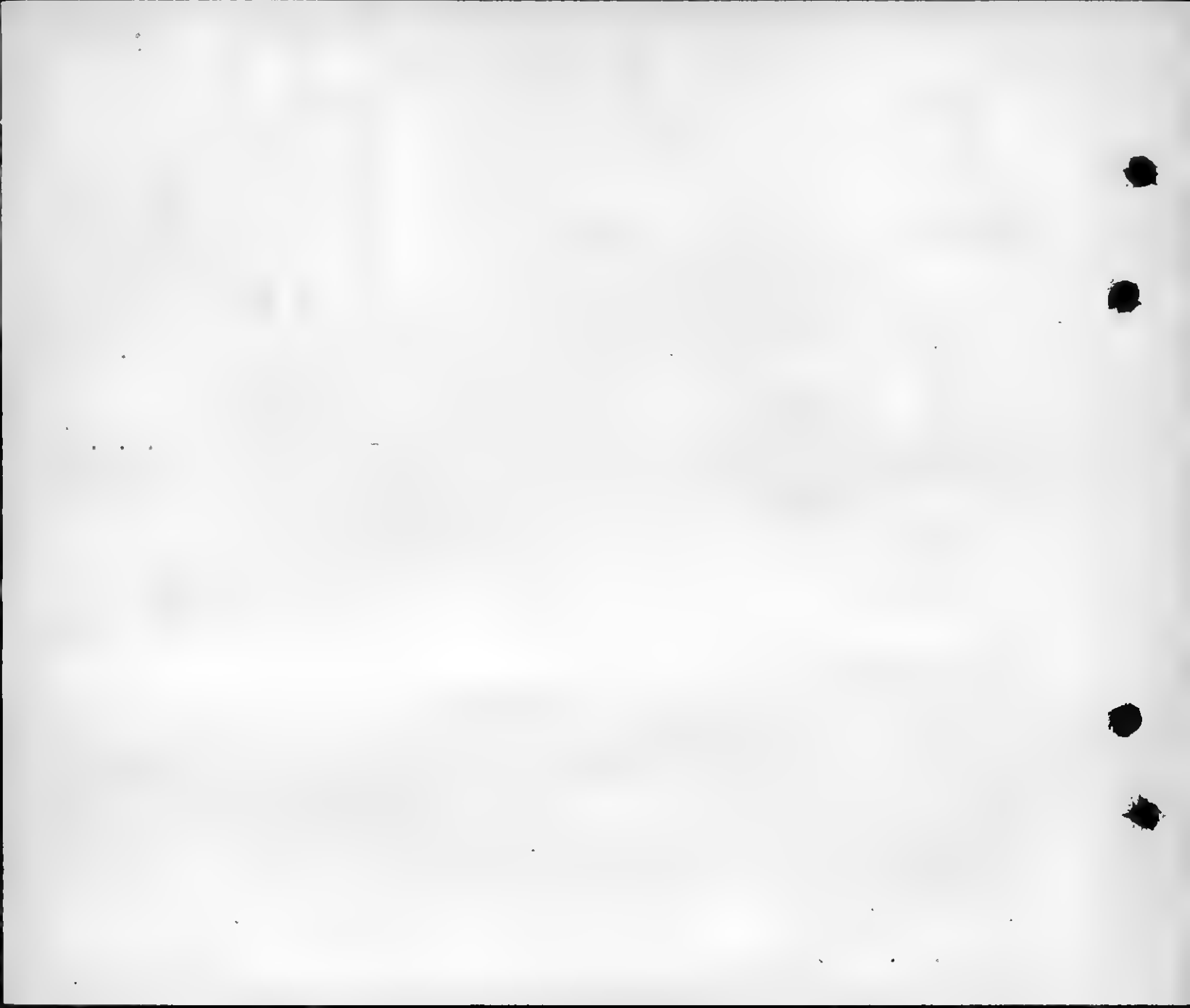
06868

6905

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WASHINGTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON MD</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Sanitarium</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ALFRED N. BAILEY</b>		4. DATE OF DEATH <b>June 19 1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 6, 1873</b>
9. AGE (In years last birthday) <b>86 yrs</b>		10. IF UNDER 1 YEAR: Months <b>11</b> Days <b>19</b> Hours <b>59</b> Min. <b>59</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rooming House Operator - self</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Michigan</b>	
11. BIRTHPLACE (State or foreign country) <b>Michigan</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Seth Bailey</b>		14. MOTHER'S MAIDEN NAME <b>FLORA MARSHALL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>none</b>	
17. INFORMANT <b>Louise Bailey - 3024 Rodman St. N.W.</b>		Address <b>Washington, DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage - 2 days prior</b> DUE TO <b>Congestive Heart Failure - 2 days prior</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Arteriosclerosis Sclerotized</b> <b>yes</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>yes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/18/59</b> , 19 <b>59</b> , to <b>6/19/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/18/59</b> , 19 <b>59</b> , and that death occurred at <b>3:45 P.M.</b> , from the causes and on the date stated above.		DATE SIGNED <b>6/19/59</b>	
ACTUAL SIGNATURE <b>SAM ALLEN, M.D.</b>		ADDRESS (Street, city or town, state) <b>Kensington, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>SAM ALLEN, M.D.</b>		M.D. <b>Kensington, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>6/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill</b>		22d. LOCATION (City, town, or county) (State) <b>White Cloud, Michigan</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company</b>		ADDRESS <b>Washington, D.C.</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6906 CERTIFICATE OF DEATH

06869

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Alta Vista Rest Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4814 Bradley Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Georgia</b> First Middle Last <b>Banham</b>		4. DATE OF DEATH Month Day Year <b>June 21, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17, 1868</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>5</b>	11. IF UNDER 24 HRS Hours <b>5</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Robbins</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Moody</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Lillian Rankin - Item#2-daughter</b>	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Ventricular Fibrillation</b> 4 x 10.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Myocarditis</b> (c) <b>Arteriosclerotic Heart Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. WAS AUTOPSY PERFORMED? <b>Generalized Arteriosclerosis Cerebrovascular Hemorrhage</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>Undetermined</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 1, 1959</b> to <b>June 21, 1959</b> , that I last saw the deceased alive on <b>May 13, 1959</b> , and that death occurred at <b>6 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10620 Georgia Ave. June 21, 1959</b> DATE SIGNED ACTUAL SIGNATURE <b>George L Ball</b> M.D. PHYSICIAN'S NAME (Type) <b>Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-24-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Puma</b>			

CORONER NOTIFIED AND WILL APPROVE.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6873

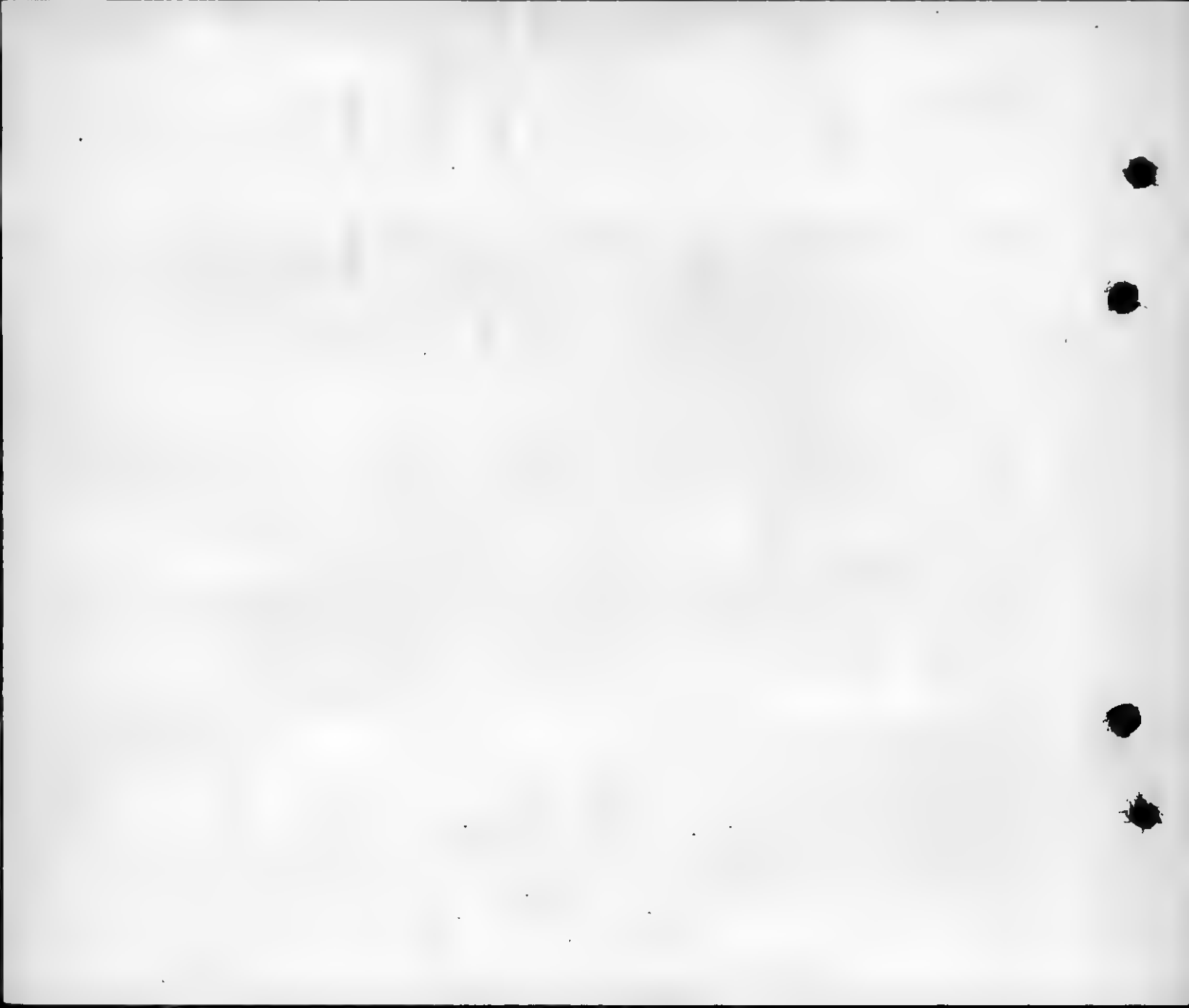
Item 12 of 12-11-59 et  
Item 22 of 12-11-59 et

CERTIFICATE OF DEATH

Reg. Dist. No.

06870

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>10 hrs.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium and Hosp.</u>		d. STREET ADDRESS <u>1511 Gridley Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Soosey</u> Middle <u>—</u> Last <u>Bargad</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-3-75</u>	9. AGE (In years last birthday) <u>84</u> yrs	IF UNDER 1 YEAR Months <u>5</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None - Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Jacob Bargad</u>		14. MOTHER'S MAIDEN NAME <u>Eida Coca</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Washington San. &amp; Hosp. Records - Takoma Park Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Generalized arteriosclerosis</u> Underlying cause (c) <u>Semility</u>					INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>June 1, 1949</u> to <u>June 8, 1959</u> , that I last saw the deceased alive on <u>June 8, 1959</u> , and that death occurred at <u>7:22 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Erwin Steinman M.D.</u>		ADDRESS (Street, city or town, state) <u>3500-14th ST. NW</u>		DATE SIGNED <u>June 8/59</u>	
PHYSICIAN'S NAME (Type) <u>ERWIN STEINMAN M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-9-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Washington</u>		22e. (State) <u>D.C.</u>		22f. (Country) <u>U.S.A.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Sanyanck</u>		ADDRESS <u>3500-14th ST NW</u>		24a. REC'D BY REGISTRAR <u>June 9 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>	





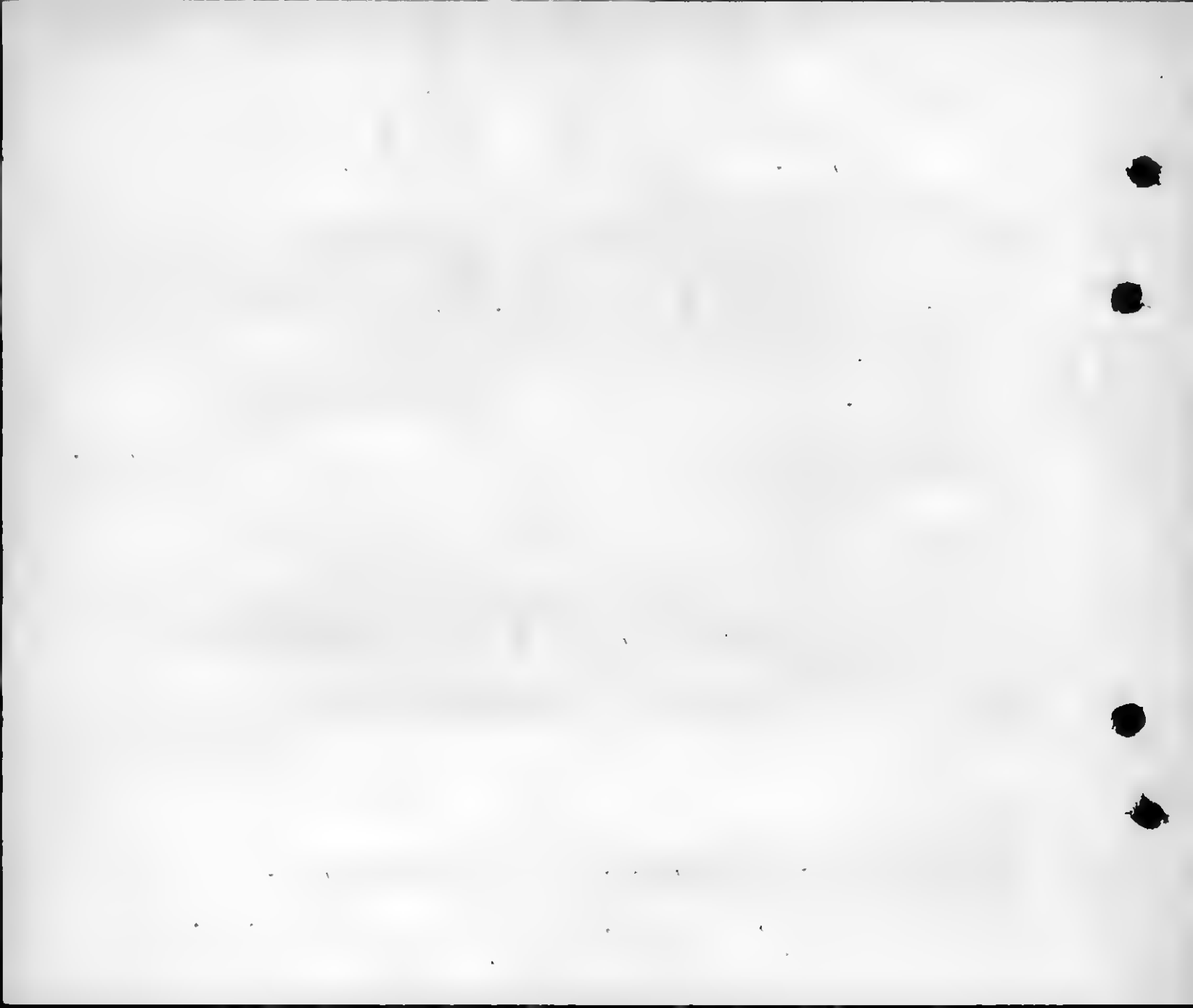
## 6907 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney, Md.</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Monrovia,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery County General</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Emma Ewing Beall</b>		4. DATE OF DEATH Month Day Year <b>6 27 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4.20.1889</b>
9. AGE (In years last birthday) yrs <b>70</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Thomas W. Beall</b>		14. MOTHER'S MAIDEN NAME <b>Mary Frances Burdette</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Lucille B. Smith</b>		Address <b>Monrovia, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>diabetes mellitus</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>multiple coronary occlusions</b> DUE TO (c) <b>gen. art. scler., diabetic gangrene</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident, gen. art. scler., diabetic gangrene</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Damascus, Md.</b>		(County) (State)	
21. I certify that I attended the deceased from <b>Aug. 20, 1958</b> , to <b>June 27, 1959</b> , that I last saw the deceased alive on <b>June 26, 1959</b> , and that death occurred at <b>3:57 p. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Damascus, Md.</b> DATE SIGNED <b>June 30 1959</b>			
ACTUAL SIGNATURE <b>G. F. Meadors</b> M.D.			
PHYSICIAN'S NAME (Type) <b>G. F. Meadors, M.D.</b> <b>Damascus, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 30, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt. View</b>	22d. LOCATION (City, town, or county) (State) <b>Purdum, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Olin L. Moleworth</b> ADDRESS <b>Damascus, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6908

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06872

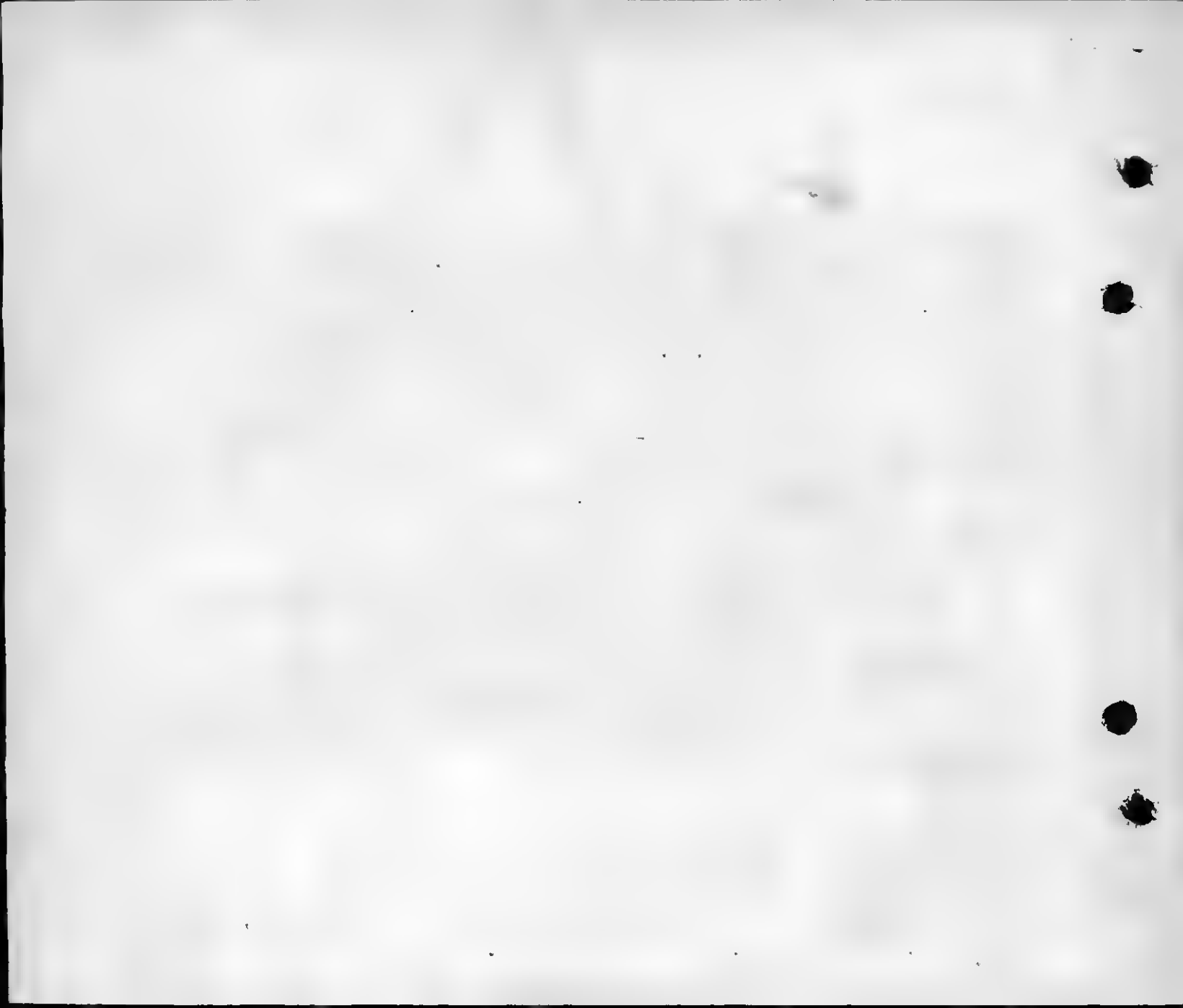
Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Monty</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		d. STREET ADDRESS <u>12328 Collesville Rd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>12328 Collesville Rd</u>		e. IS RECORD MADE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Vincent Bean Sr.</u>		4. DATE OF DEATH <u>June 4 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>5-19-1908</u>
9. AGE (in years and birthday) <u>51</u> yrs		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>machinist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Navy Yard</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas J. Bean</u>		14. MOTHER'S MAIDEN NAME <u>Helen Craft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-18-6829</u>	
17. INFORMANT <u>Joseph T. Bean</u>		Address <u>Stem 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (a), stating the underlying cause lost. DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/9/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Burtonsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>		DATE <u>June 4 1959</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Board of Health. TO FUNERAL DIRECTOR: Page 5 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



# 1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6909

## CERTIFICATE OF DEATH

06873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b <b>10 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery County General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Walter</b> Middle <b>Smith</b> Last <b>Bellison</b>				4. DATE DEATH Month <b>June</b> Day <b>12</b> Year <b>19 59</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8.30.99</b>	9. AGE (In years last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min <b>59</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N. I. H.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>James Bellison</b>				14. MOTHER'S MAIDEN NAME <b>Emily Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>4x201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary artery disease</b> DUE TO (c) <b>2 years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>few days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 11, 1959</b> to <b>June 12, 1959</b> , that I last saw the deceased alive on <b>June 12, 1959</b> , and that death occurred at <b>9:40p M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. A. Linthicum</b> M. D.				ADDRESS (Street, city or town, state) <b>Gaithersburg, Md.</b>		DATE SIGNED <b>6.12.59</b>	
PHYSICIAN'S NAME (Type) <b>W. A. Linthicum, M. D., Gaithersburg, Md.</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Park Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Linthicum</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 18 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanna</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 1 may be retained by the hospital. The attending physician, after the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





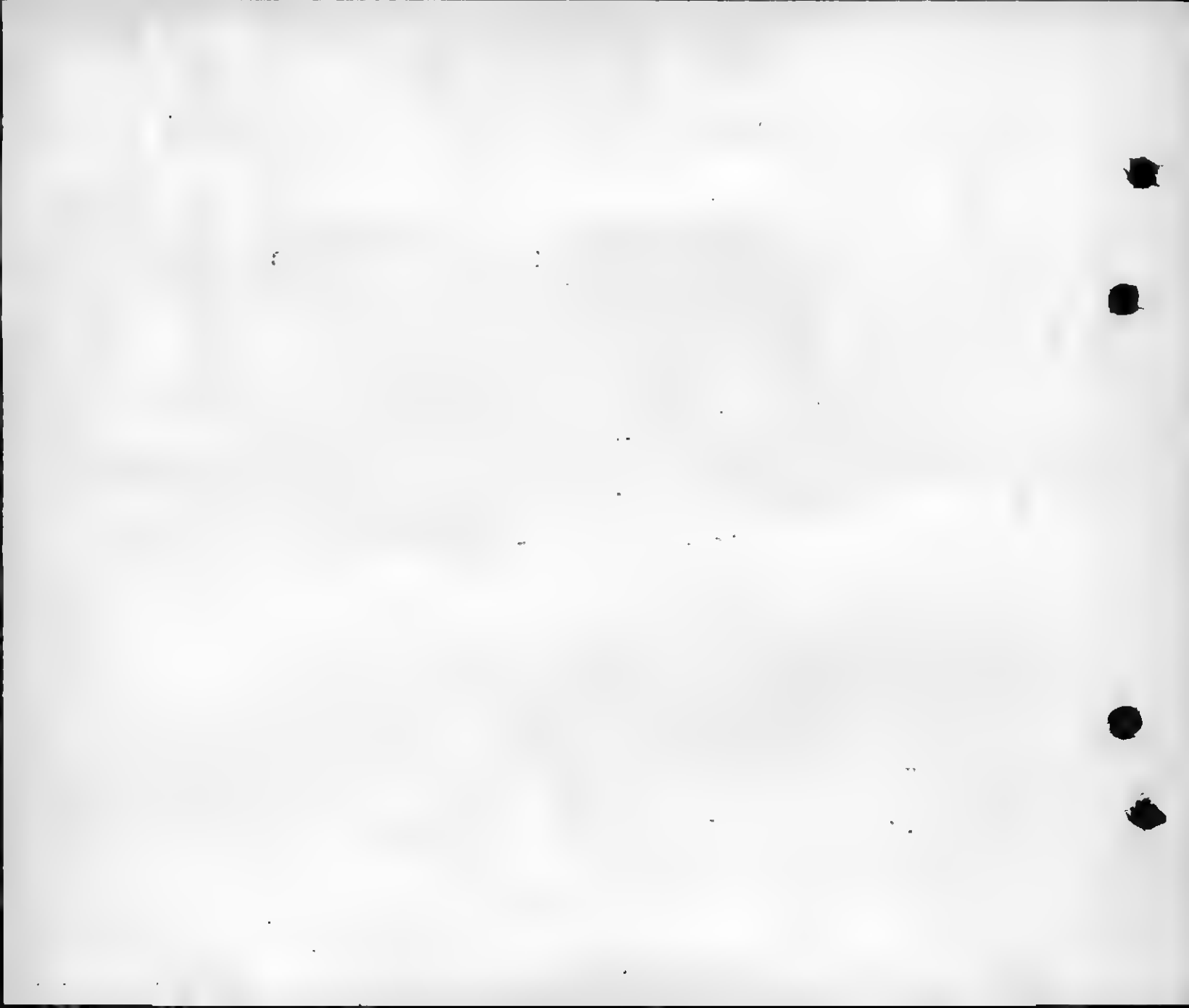
6910

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>D.C.</b> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b>		c. LENGTH OF STAY IN 1b <b>5 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Asbury Methodist Home</b>		e. STREET ADDRESS <b>1514 Emerson St. N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>Annie May Bendall</b>		4. DATE OF DEATH <b>JUNE 30 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <b>5-4-1876</b>
8. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School-teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Thomas Bendall</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Stone</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>—</b>	
17. INFORMANT <b>Asbury Methodist Home - Gaithersburg</b>		Address <b>MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>445X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>congestive heart failure</b> (c) <b>hypertensive cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12-28 1955</b> to <b>June 30 1959</b> , that I last saw the deceased alive on <b>June 28 1959</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Sarah E. Glover</b>		ADDRESS (Street, city or town, state) <b>10128 CEDAR LAKE NEWINGTON, MD</b>	
PHYSICIAN'S NAME (Type) <b>Sarah E. Glover</b>		DATE SIGNED <b>6-30-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 2, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Warrenton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Warrenton, Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Albion</b> ADDRESS <b>316 E Diamond Ave Gaithersburg, Md</b>		24a. REC'D BY REGISTRAR <b>JUL 2 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, fill in pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6911

## CERTIFICATE OF DEATH

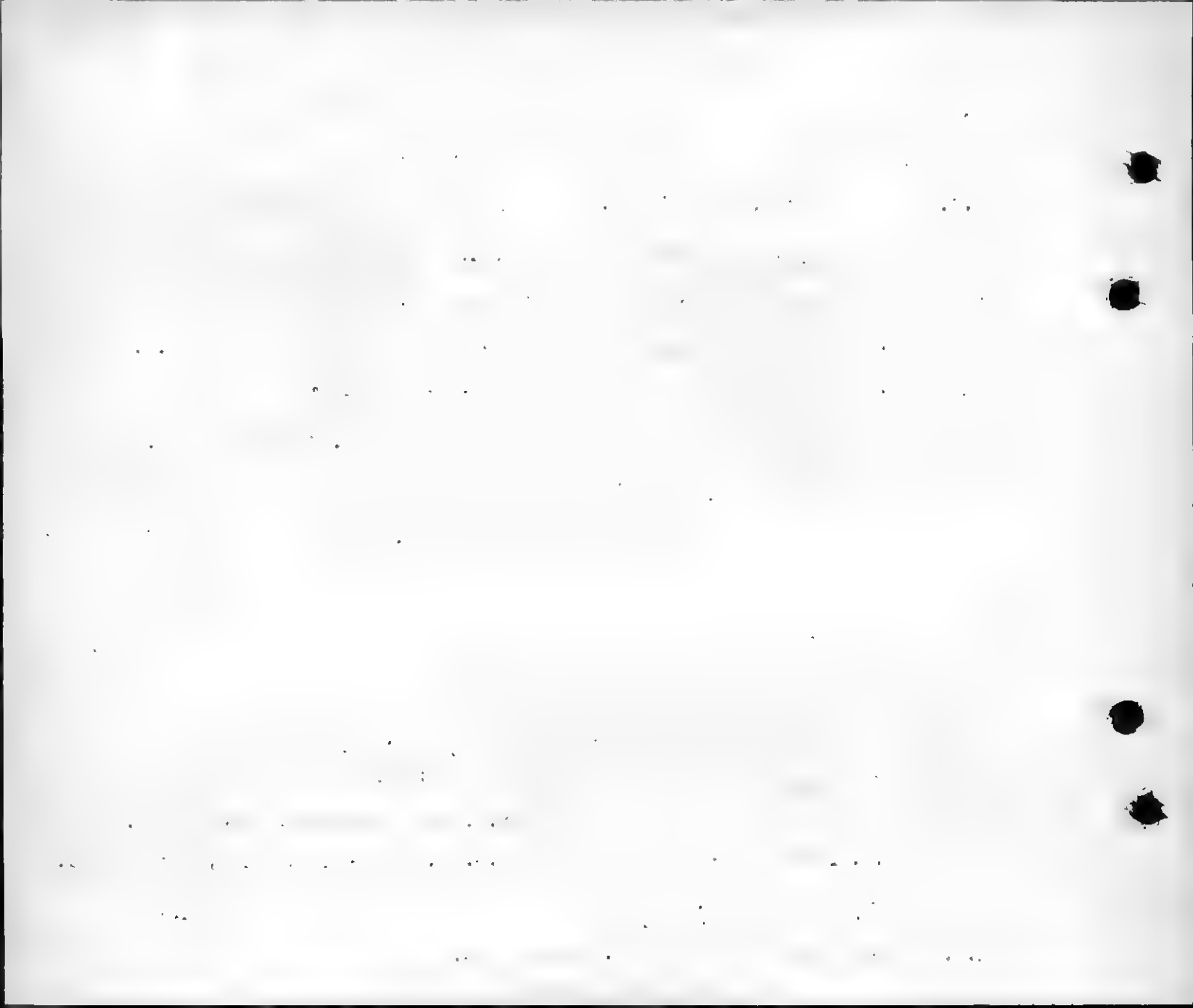
Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>			2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Arlington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> d. STREET ADDRESS <b>2407 North Roosevelt Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret (n) BENTLEY</b>			4. DATE OF DEATH Month Day Year <b>June 12 19 59</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 April 1872</b>		9. AGE (In years last birthday) yrs. <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Scotland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>
13. FATHER'S NAME <b>John MEIKLE</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth PENANT</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>(Daughter) Edith M. GORDANIER</b>		Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute renal failure</b> DUE TO (b) <b>Carcinoma pancreas</b> DUE TO (c) <b>unknown</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <b>13 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic jaundice</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Hospital, Bethesda Md.</b>	
20f. (City or town) <b>Spokane, Washington</b>		(County) <b>Spokane</b>		(State) <b>Washington</b>	
21. I certify that I attended the deceased from <b>22 May 19 59</b> to <b>12 June 19 59</b> that I last saw the deceased alive on <b>12 June 19 59</b> , and that death occurred at <b>06:15 AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md.</b> DATE SIGNED <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>					
ACTUAL SIGNATURE <b>W.D. HOOFFER</b> M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>					
PHYSICIAN'S NAME (Type) <b>W.D. HOOFFER LT MC USN</b> <b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial - Shipment 6-14-59</b>		22b. DATE THEREOF <b>6-14-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Riverside</b>	
22d. LOCATION (City, town, or county) <b>Spokane, Washington</b>		(State) <b>Washington</b>		24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24c. ADDRESS <b>7557 Wisconsin Ave. Bethesda Md.</b>	

1

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician has been signed by the attending physician and completed by the funeral director. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
TSM 9/58



6874

## CERTIFICATE OF DEATH

06876

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47th St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oak Haven Conv Home 517 Albany Ave</u>		d. STREET ADDRESS <u>202 Van Buren St. N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>Katherine Brittain Blackwood</u>		4. DATE OF DEATH <u>June 1 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-1872</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Brittain</u>		14. MOTHER'S MAIDEN NAME <u>Payne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NE</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Ann L. Solem</u>		Address <u>202 Van Buren St. Wash. D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Cor. of heart in 1959</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2.1</u> DUE TO <u>2.1</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 1, 1959</u> , to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>June 1, 1959</u> , and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip E. K...</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/3/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>
22d. LOCATION (City, town, or county) <u>Washington, D.C.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. King Co 2901-14th St N.W. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. King</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6912 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06877

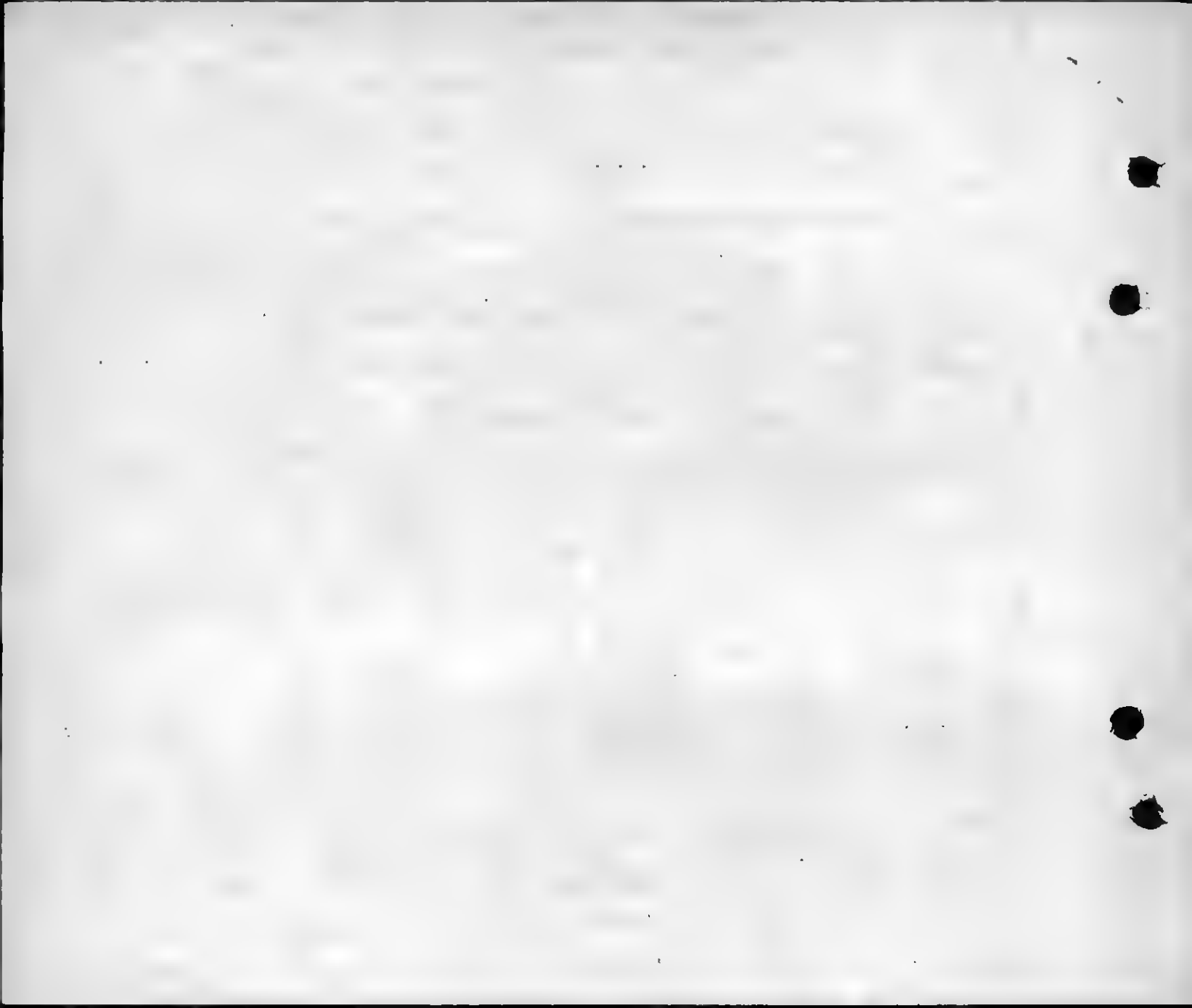
Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D.O.A.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kenwood</u> d. STREET ADDRESS <u>5804-Brookside Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Joseph Devereux Blair</u>				<b>4. DATE OF DEATH</b> Month Day Year <u>June 19, 19 59</u>					
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Sept. 26, 1956</u>		<b>9. AGE</b> (In years last birthday) <u>2yrs.</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>23</u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>District of Columbia</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>Clay Drewry Blair</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Agnes Kemp Devereux</u>					
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>				<b>17. INFORMANT</b> <u>Patricia Devereux Aunt</u> Address <u>  </u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TRAUMATIC SHOCK</u> DUE TO <u>LACERATIONS OF LIVER AND SPLEEN</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO <u>AUTOMOBILE ACCIDENT</u> (c) <u>  </u>								INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Walked on street in front of approaching car</u>				<b>20c. TIME OF INJURY</b> Month, Day, Year <u>1:15 p.m. 6/19/59</u>	
<b>20d. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>street</u>				<b>20f. (City or town)</b> <u>Kenwood</u> (County) <u>Montg.</u> (State) <u>Md.</u>	
<b>21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								<b>DATE SIGNED</b> <u>6/20/59</u>	
<b>ACTUAL SIGNATURE</b> <u>Frank Broschart</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>EXAMINER'S NAME (Type)</b> <u>Frank Broschart</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6/23/1959</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Arlington</u> (State) <u>Virginia</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey Bethesda, Maryland</u>						<b>24a. REC'D BY, REGISTRAR</b> <u>DATE JUN 23 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

MEDICAL CERTIFICATION

15

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 14 days after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the funeral director or your files. Forwarded to the Chief Medical Examiner's Office along with form PH43. Page 5 may be retained by the registrar prior to burial, cremation, or removal. TO FUNERAL DIRECTOR: Pages 1, 2, and 3 should be used as a burial-transit permit. File pages 1 and 2.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6913

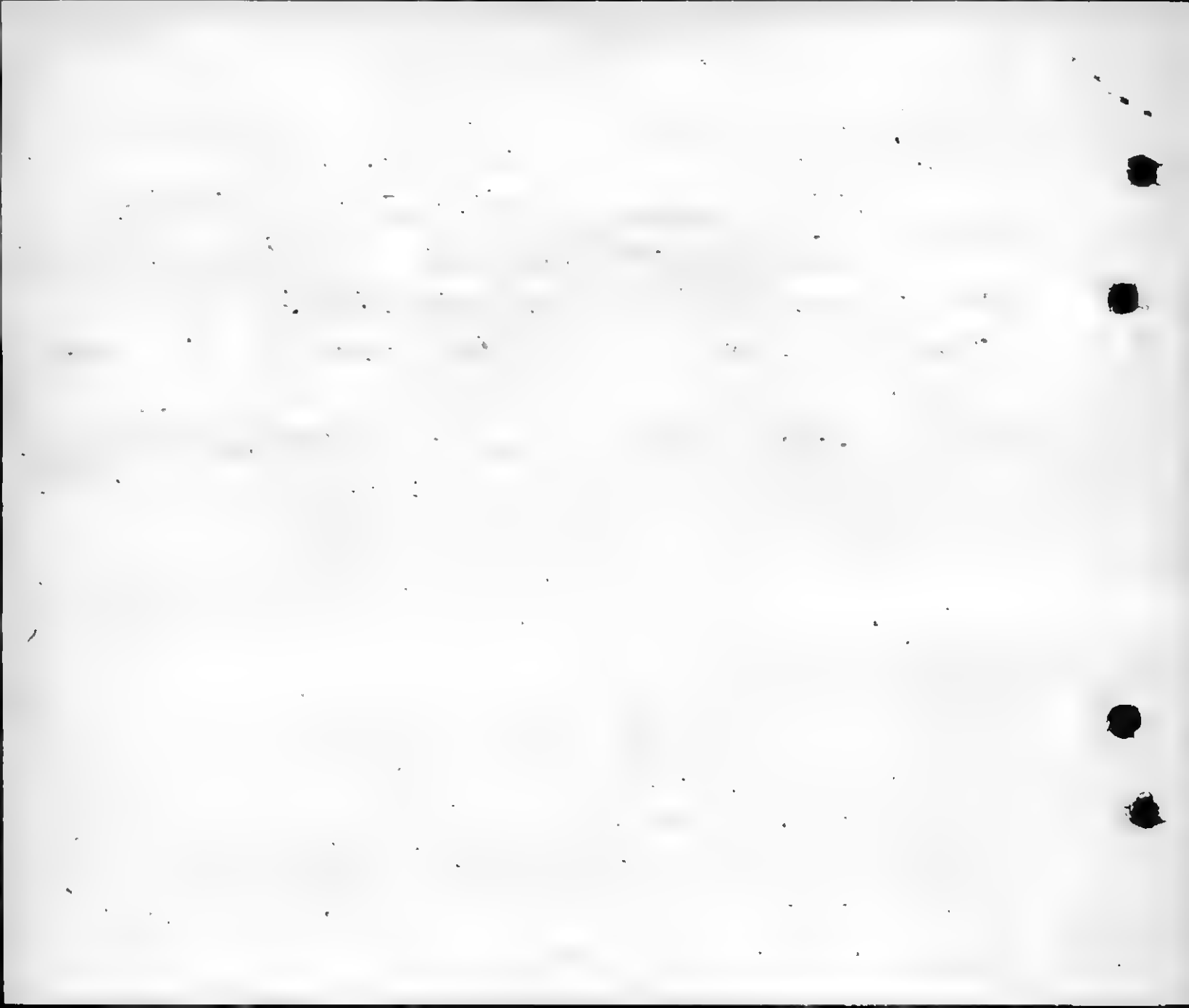
## CERTIFICATE OF DEATH

06878

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>9609-Bull Run Parkway</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elie A. Borda</u>		4. DATE OF DEATH Month Day Year <u>June 30 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 20, 1894</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <u>4 20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Composer of music</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>	
11. BIRTHPLACE (State or foreign country) <u>France</u>		12. CITIZEN OF WHAT COUNTRY? <u>France</u>	
13. FATHER'S NAME <u>Unknown Alfred Borda</u>		14. MOTHER'S MAIDEN NAME <u>Unknown Gracianne Mainard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown, (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Gabriel P. Bunsky</u> Address <u>9609 Bull Run Parkway Bethesda, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>332X</u> DUE TO <u>INFARCTION OF BRAIN STEM</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>BASILAR ARTERY OCCLUSION</u> DUE TO <u>15 DAYS</u> (c) <u>CEREBRO-VASCULAR ARTERIO-SCLEROSIS</u> DUE TO <u>OVER 4 YEARS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CORONARY ARTERY DISEASE-OLD MYOCARDIAL INFARCT</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m p. m. <u>June 16, 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 16, 1959</u> to <u>June 30, 1959</u> that I last saw the deceased alive on <u>June 29, 1959</u> and that death occurred at <u>9:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor, M.D.</u>		ADDRESS (Street, city or town, state) <u>7420 Old Georgetown Rd Bethesda, Maryland</u> DATE SIGNED <u>June 30, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-2-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUL 6 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Charles S. Krumm</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6914 CERTIFICATE OF DEATH

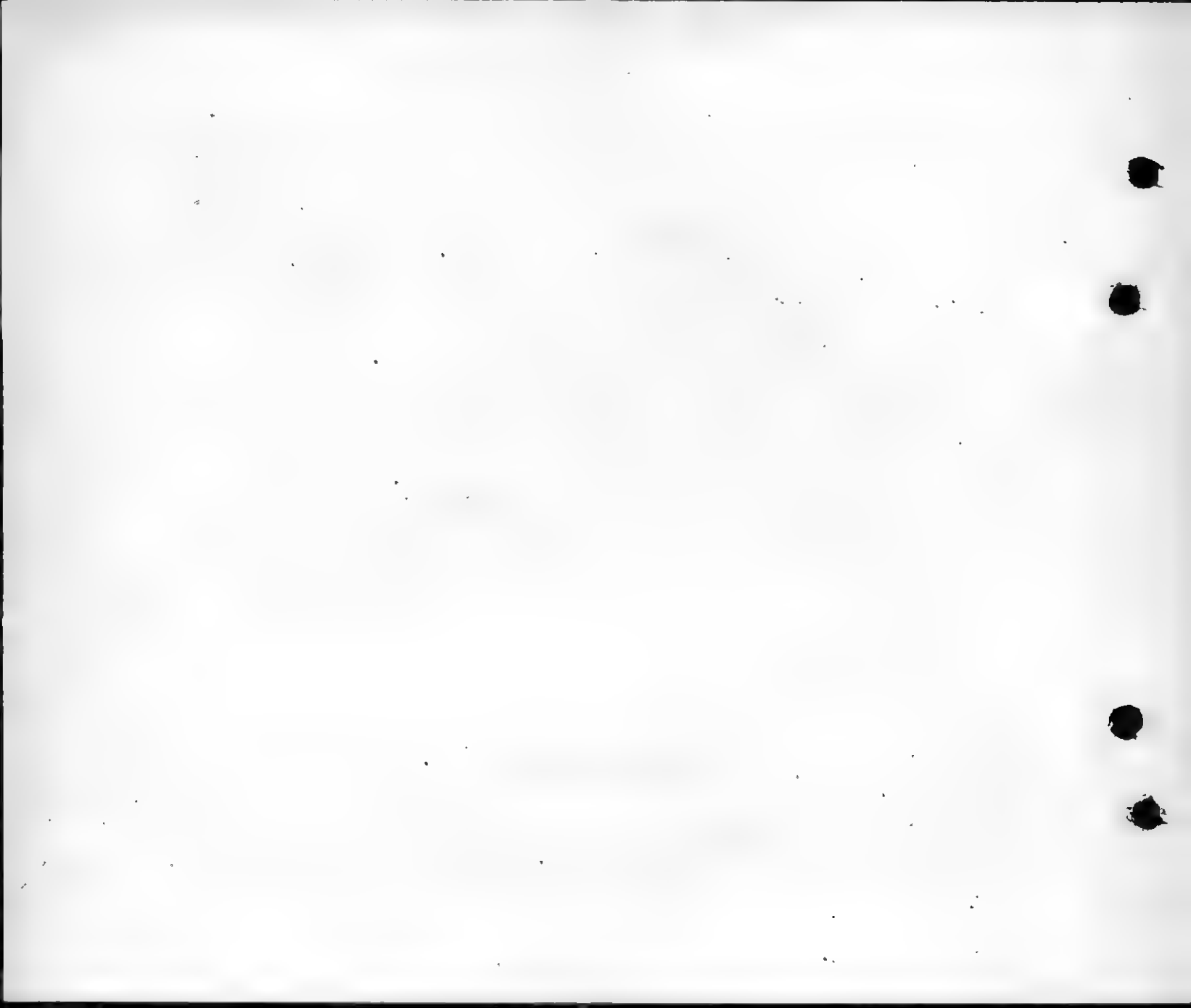
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Dist. of Col.</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		c. LENGTH OF STAY IN 1b _____	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Vincent Berger</u>		4. DATE OF DEATH <u>June 21 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 6 1912</u>
9. AGE (In years last birthday) <u>47</u> yrs	10. IF UNDER 1 YEAR Months _____ Days _____	11. IF UNDER 24 HRS Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Packing Dist. of Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Henry Berger</u>		14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>154-11-10000</u>	
17. INFORMANT <u>Beatrice C. Berger - wife</u>		Address <u>same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>HYPERTENSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Jan 5 1949</u> to <u>June 21 1959</u> that I last saw the deceased alive on <u>June 21 1959</u> , and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8016 Georgetown Rd. Bt 6/21/59</u> DATE SIGNED <u>Leo I. Donovan M.D.</u>			
ACTUAL SIGNATURE <u>Leo I. Donovan M.D.</u>		PHYSICIAN'S NAME (Type) <u>Leo I. Donovan M.D.</u>	
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>	22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Helene's Funeral Home</u> ADDRESS <u>3605-14 St N.W.</u>		24. REC'D BY REGISTRAR DATE <u>JUN 23 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>			

**TO HOSPITAL OR CORONING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6915

## CERTIFICATE OF DEATH

06880

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2 USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. STREET ADDRESS <b>4000 Cathedral Ave. NW</b> <b>Old Georgetown Rd.</b> <b>Bethesda, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Fanny</b> First <b>P.</b> Middle <b>Bowersock</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9 Oct. 1870</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>(Unkown) Pickering</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>J. L. Sheldon</b>		Address <b>730 15 th. St. Wash. D. C.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myelogenous Leukemia, chronic</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 months</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary atherosclerotic heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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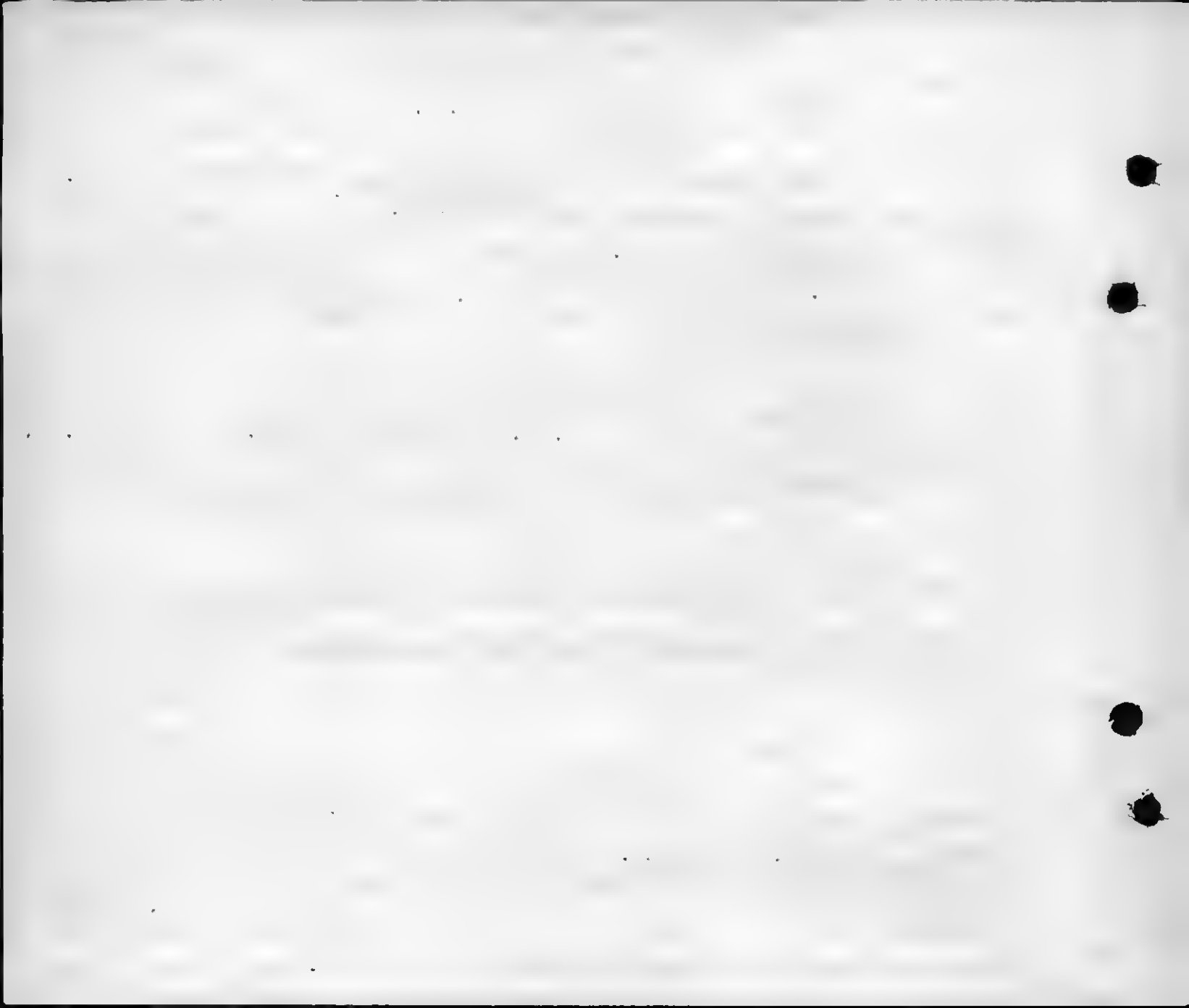
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>a. n.</b> Month, Day, Year <b>19</b> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>June 10, 1958</b> , to <b>June 30, 1959</b> , that I last saw the deceased alive on <b>June 29, 1959</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Seruch T. Kimble</b>	M.D. <b>2290 Washington Dr. Lake Spring Md</b>
PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble, M.D.</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Cremation</b>	<b>July 1st. 1959</b>	<b>Lees Crematorium</b>	<b>Washington D.C.</b>

23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>	ADDRESS <b>300 4th Ave Wash DC</b>	24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



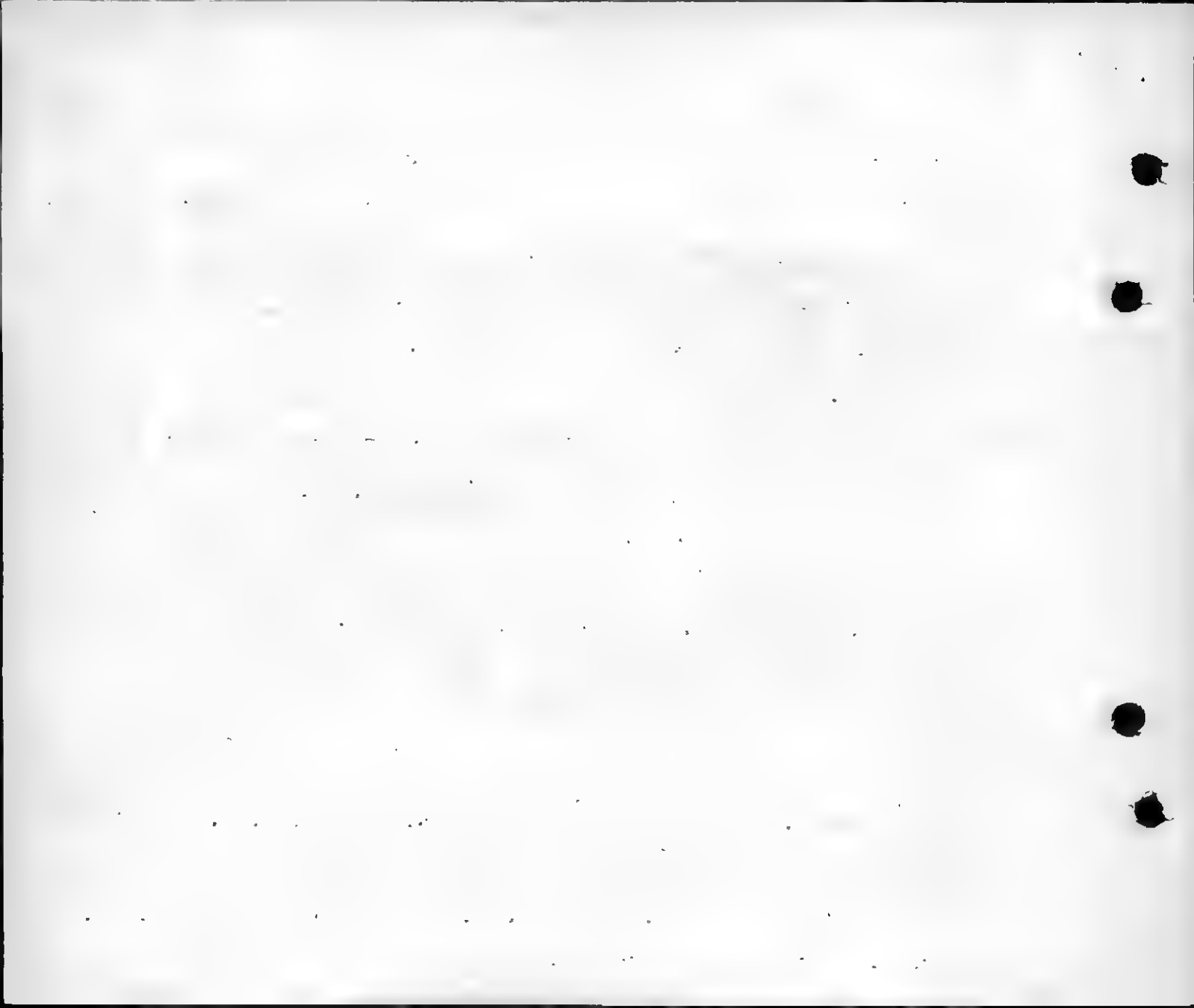


## 6916 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. LENGTH OF STAY IN 1b <b>X</b> <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4204 Stanford Street</b>		d. STREET ADDRESS <b>4204 Stanford Street</b>	
3. NAME OF DECEASED (Type or print) First <b>LILLIAN MAY MOORE</b> Middle <b>Breslin</b> Last <b>Breslin</b>		4. DATE OF DEATH Month <b>6</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 12, 1874</b>
9. AGE (In years last birthday) yrs <b>85</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>3</b> Days <b>8</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Penna.</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>William K. Bowman</b>	
14. MOTHER'S MAIDEN NAME <b>Ida Creamer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Bowman H Moore-son-same as 2d</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Heart Disease</b> <b>444X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) <b></b>			INTERVAL BETWEEN ONSET AND DEATH <b>5-6 yrs</b> <b>10 yrs +</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cotostomy &amp; Removal of Ca Rectum 1946</b>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 12, 1946</b> to <b>June 17, 1959</b> that I last saw the deceased alive on <b>6-10-1959</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George R. Huffman</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>1912 R. Street, N. W. 6/17/59</b>	
PHYSICIAN'S NAME (Type) <b>George R. Huffman</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/19/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Prince George Co. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 19 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clara S. Kious</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital. The attending physician may be retained by the hospital. After the certificate has been signed by the attending physician and completed, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

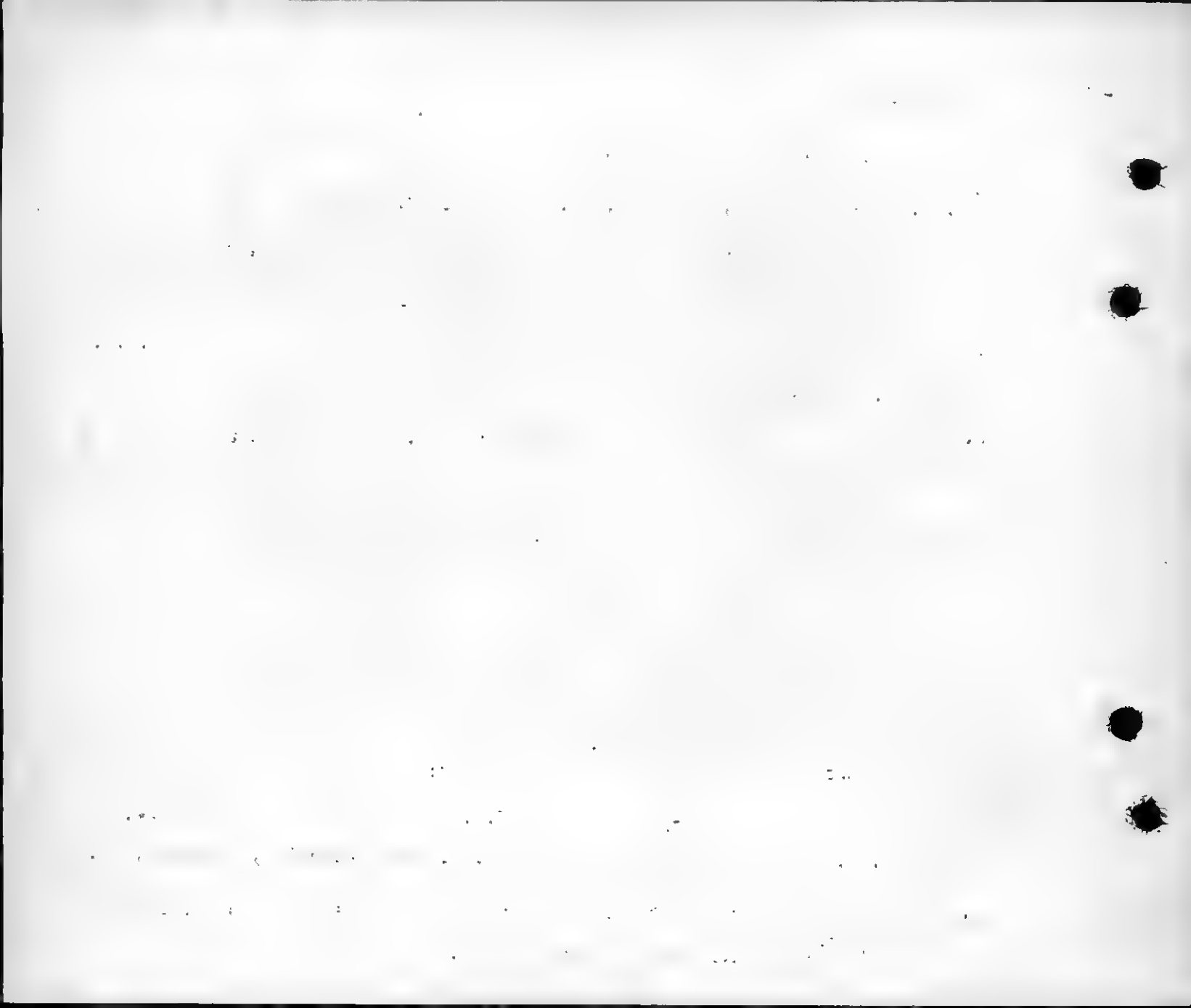


## 6917 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>34 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bethesda, Md.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <input checked="" type="checkbox"/> <b>Alexandria</b>	
d. STREET ADDRESS <b>226 E. Nelson Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Deborah</b> Middle <b>Ann</b> Last <b>BROOKS</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>28 April 1959</b>
9. AGE (In years last birthday) yrs. <b>1</b> Months <b>13</b> Days <b>13</b> Hours <b>13</b> Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas M. Brooks</b>		14. MOTHER'S MAIDEN NAME <b>Florence Bond</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>(Mother) Mrs. Florence Brooks Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Prematurity</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Extrophy of bladder (congenital)</b> (b) <b>4</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>7 May</b> , 19 <b>59</b> , to <b>10 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>10 June</b> , 19 <b>59</b> , and that death occurred at <b>3:35A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda Md.</b>			
ACTUAL SIGNATURE <b>H. L. Walton</b>		M.D. <b>U. S. Naval Hospital, Bethesda, Md.</b>	
PHYSICIAN'S NAME (Type) <b>H. L. WALTON LT MC USN</b>		U. S. Naval Hospital, Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12 JUNE 59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Falls Church Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter H. Hall</b>		24a. REC'D BY REGISTRAR <b>Cunningham's 809 Cameron Street Alexandria Va.</b>	24b. REGISTRAR'S SIGNATURE <b>DATE JUN 12 '59</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or funeral home. The attending physician and coroner must be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



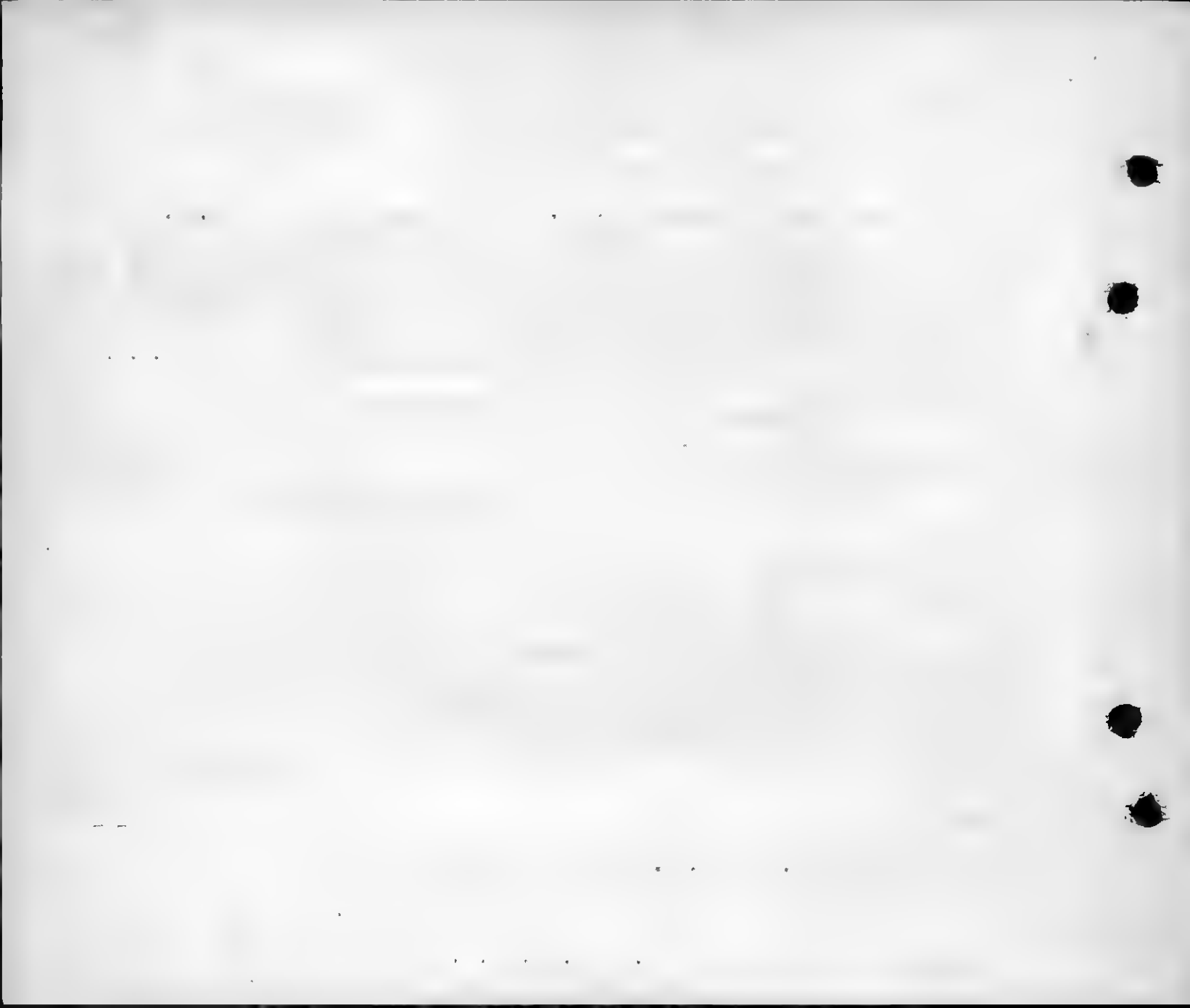
06883

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>43 days</b>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		d. STREET ADDRESS <b>4007 Connecticut Avenue, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Marion</b>		First <b>Marion</b>		Middle <b>(None)</b>		Last <b>Brooks</b>		4. DATE OF DEATH Month <b>June</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>15 March 1902</b>		9. AGE (In years last birthday) <b>57 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Finance Corporation</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Francis Brooks</b>				14. MOTHER'S MAIDEN NAME <b>Mary McArdle</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578-36-0347</b>		17. INFORMANT The Medical Record Address <b>The Clinical Center, Bethesda 14, Maryland</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Progressive respiratory failure</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Metastatic Carcinoma of Breast</b> DUE TO (c) <b>9 mos.</b>								INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)	
21. I certify that I attended the deceased from <b>April 21</b> , 19 <b>59</b> , to <b>June 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 3</b> , 19 <b>59</b> , and that death occurred at <b>6:20A</b> M, from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Richard H. Moy</b>		M. D. <b>The Clinical Center</b>		ADDRESS (Street, city or town, state) <b>National Institutes of Health</b>		DATE SIGNED <b>6-3-59</b>			
PHYSICIAN'S NAME (Type) <b>Richard H. Moy, M. D.</b>				<b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/6/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Fredericksburg, Va</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Henderson</b>		ADDRESS <b>1756 Pa. Ave. NW, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After the death certificate has been signed by the attending physician and completed by filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6919 CERTIFICATE OF DEATH

06884

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>18 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Montgomery County General Hospital, Inc.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Beulah Louise Brown</b>		4. DATE OF DEATH Month Day Year <b>6.11. 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12.18.81</b>
9. AGE (In years last birthday) <b>77 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Charles A. Gartrell</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Grooms</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Hospital Records</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <b>Acute pyelonephritis with numerous Abscess - Acute necrotizing cystitis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Bronchopneumonia</b>			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/11</b> , 19 <b>58</b> , to <b>6/11</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/10</b> , 19 <b>59</b> , and that death occurred at <b>8:45 a.m.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Sandy Spring, Maryland</b> DATE SIGNED <b>6/11/59</b> SIGNATURE <b>Sandy Spring</b> PHYSICIAN'S NAME (Type) <b>J. W. Bird, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 13</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Sunshine Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rayon Barber Laytonsville, Md.</b>		24. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hana</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove the paper pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





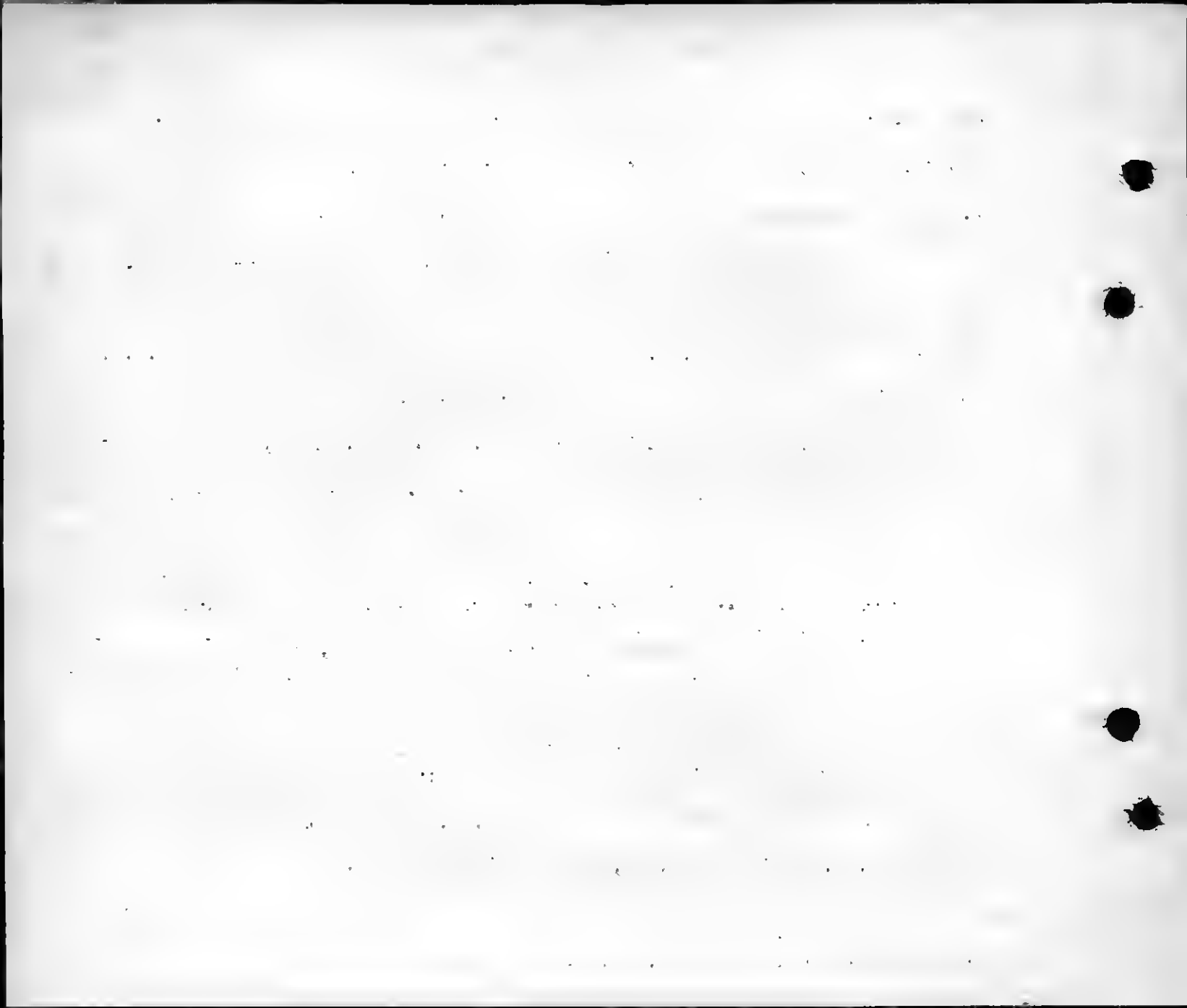
6920

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>68 days</b> d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>Utah</b> b. COUNTY <b>Salt Lake City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salt Lake City</b> d. STREET ADDRESS <b>930 W. North Temple</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>William</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-18-23</b>
9. AGE (In years last birthday) <b>35 yrs</b>		10. IF UNDER 1 YEAR Months <b>35</b>	11. IF UNDER 24 HRS Days <b>35</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>	11. BIRTHPLACE (State or foreign country) <b>Colorado</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Foster BROWN</b>	
14. MOTHER'S MAIDEN NAME <b>Estella REESE</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	
16. SOCIAL SECURITY NO. <b>561-26-5416</b>		17. INFORMANT <b>(W) Mrs. Louella C. Brown, same as #2 above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA &amp; SEPTICEMIA (BILATERAL)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LEUKOPENIA &amp; APLASTIC ANEMIA</b> DUE TO (c) <b>TOTAL BODY IRRADIATION OF 700 R GIVEN 4 WEEKS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b> <b>4 WEEKS</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. TREATMENT OF WIDESPREAD RECURRENT EMBRYONAL CELL <b>CARCINOMA OF TESTES. OF 7 YEAR'S DURATION</b>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MED CAL EXAMINER) <input type="checkbox"/>		20b. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	
20c. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U. S. Naval Hospital</b>	
20e. (City or town) <b>Bethesda</b>		20f. (County) (State) <b>MD. U. S. Naval Hospital</b>	
21. I certify that I attended the deceased from <b>March 27</b> , 19 <b>59</b> , to <b>June 23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>59</b> , and that death occurred at <b>5:45 A.M.</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Bethesda, Md.</b>	
ACTUAL SIGNATURE <b>F. S. Caldwell</b>		DATE SIGNED <b>6/23/59</b>	
PHYSICIAN'S NAME (Type) <b>F. S. Caldwell, LT, MC, USN</b>		22. LOCATION (City, town or county) (State) <b>Fort Douglas Utah</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>		22b. DATE THEREOF <b>6-28-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Army Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Fort Douglas Utah</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest A. Adams</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>		24c. REGISTRAR'S NAME <b>Arthur S. Hume</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



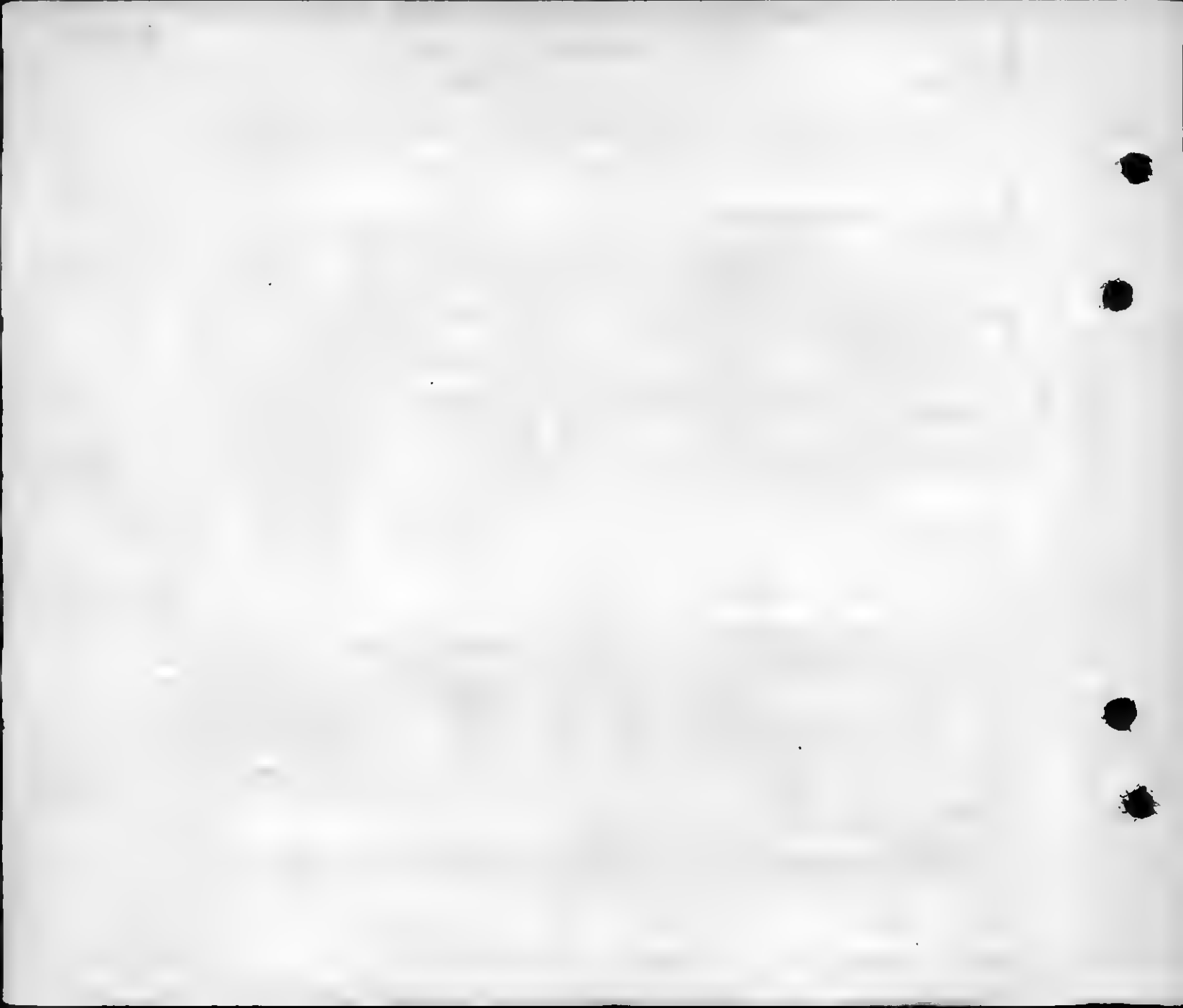
6875 CERTIFICATE OF DEATH

06886

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) o STATE <i>D.C.</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington San &amp; Hospital</i>				d. STREET ADDRESS <i>1300 Vermont Ave N.W.</i>			
3. NAME OF DECEASED (Type or print) First <i>Myrtie</i> Middle <i>Lee</i> Last <i>Bunch</i>				4. DATE OF DEATH Month <i>6</i> Day <i>21</i> Year <i>1959</i>			
5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-15-84</i>	
9. AGE (In years last birthday) <i>74</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Chandler</i>				14. MOTHER'S MAIDEN NAME <i>Gabriel Bunch</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>None</i>				16. SOCIAL SECURITY NO. <i>Husband &amp; old W.S.H. Records</i>			
17. INFORMANT Address <i>Husband &amp; old W.S.H. Records</i>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cornary Arteriosclerosis</i>				INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i>			
420.1 DUE TO <i>Chronic Myocarditis Angina</i>				1/7/59			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Severe Aortic Aneurysm</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>RT lobar pneumonia - left lobe bronchogenic</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <i>19</i> Day <i>19</i> Year <i>1959</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>11/21/1959</i> to <i>6/21/1959</i> , that I last saw the deceased alive on <i>6/21/1959</i> , and that death occurred at <i>2:30 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Howard T. Moore</i> M.D.				ADDRESS (Street, city or town, state) <i>7030 Carroll Ave</i> DATE SIGNED <i>6/21/59</i>			
PHYSICIAN'S NAME (Type) <i>Takoma Park, Md</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6/23-1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN</i>		22d. LOCATION (City, town, or county) (State) <i>HYATTSVILLE. MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elizabeth Jones</i> ADDRESS <i>Home 4214 9th St</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 24 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6921 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>10 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSP.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SANDY SPRING</b> d. STREET ADDRESS <b>XXXXXX</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLIFTON WALTER BURRISS</b>				4. DATE OF DEATH Month Day Year <b>JUNE 24 19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/27/12</b>	
9. AGE (In years last birthday) yrs <b>47</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GAS STATION ATTENDANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>FRANK WALTER BURRISS</b>				14. MOTHER'S MAIDEN NAME <b>NORAELEN BURRISS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-0309091</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage from esophageal varices 10 days</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis of Liver</b> DUE TO (c) <b>Chronic Alcoholism</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>unkn.</b> <b>unkn.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>June 14, 1959</b> , to <b>June 24, 1959</b> , that I last saw the deceased alive on <b>June 24, 1959</b> , and that death occurred at <b>4:40 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Arthur F. Woodward</b> M.D.				ADDRESS (Street, city or town, state) <b>Rockville, Md.</b>			
DATE SIGNED <b>6/24/59</b>				PHYSICIAN'S NAME (Type) <b>ARTHUR F. WOODWARD, M. D.</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>June 27 -59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brookeville Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Brookeville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond Barber</b>				ADDRESS <b>Laytonsville, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove cubes, papers, pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6876 CERTIFICATE OF DEATH

06888

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i> c. LENGTH OF STAY IN b <i>1 mo. + 16 days</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>Stafford</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Stafford</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>Washingtonian Hospital</i>		d. STREET ADDRESS <i>1415 N. Hudson Street</i>	
3. NAME OF DECEASED (Type or print) <i>Grace Carrolle Burton</i>		4. DATE OF DEATH Month <i>June</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-17-87</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR: Months <i>7</i> Days <i>1</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Virginia</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas S. Cousins</i>		14. MOTHER'S MAIDEN NAME <i>Bosa T aylor</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>Chart</i>	
17. INFORMANT <i>Chart</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Mesenteric Thrombosis</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i> <i>4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Left Cerebral Infarction + Hypertension</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <i>0</i> a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1945</i> to <i>June 20, 1959</i> , that I last saw the deceased alive on <i>June 19, 1959</i> , and that death occurred at <i>2:47 PM</i> , from the causes and on the date stated above.		DATE SIGNED	
ACTUAL SIGNATURE <i>Robert A. Hare</i> M.D.		ADDRESS (Street, city or town, state) <i>1600 Carroll Ave. T.P. Md.</i>	
PHYSICIAN'S NAME (Type) <i>Robert A. Hare MD.</i>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>JUNE 24 1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>HOLLYWOOD CEMETERY</i>		22d. LOCATION (City, town, or county) (State) <i>RICHMOND VA.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Fennell</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 22 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Fennell</i>			





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Weight - 3 lbs 11 oz

6922

CERTIFICATE OF DEATH

06889

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bucharest</u>		c. LENGTH OF STAY IN 1b <u>Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>1 10807 Huntley Place</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>BUSSINK</u>		4. DATE OF DEATH Month Day Year <u>JUNE 10 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 10 1959</u>
9. AGE (In years last birthday) yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Francis BUSSINK</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA Dynosia AUTH</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Congenital atelectasis</u> DUE TO (c) <u>Immaturity</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
19a. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10</u> , 19 <u>59</u> , to <u>June 10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 10</u> , 19 <u>59</u> , and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.		ADDRESS (Street, city or town, state) <u>809 Viersburg Rd Rockville Md</u>	
PHYSICIAN'S NAME (Type) <u>JAMES S STANTON MD</u>		DATE SIGNED <u>6/10/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Collins</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 15 '59</u>	
ADDRESS <u>3821-14th St. N.W. WASH. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. The attending physician and the funeral director must sign the certificate. After the certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1900

Jan 1st

Feb 1st

Mar 1st

Apr 1st

1901

Jan 1st

Feb 1st

Mar 1st

Apr 1st

May 1st

Jun 1st

Jul 1st

Aug 1st

1902

Jan 1st

1903

Feb 1st

Mar 1st

Apr 1st

May 1st

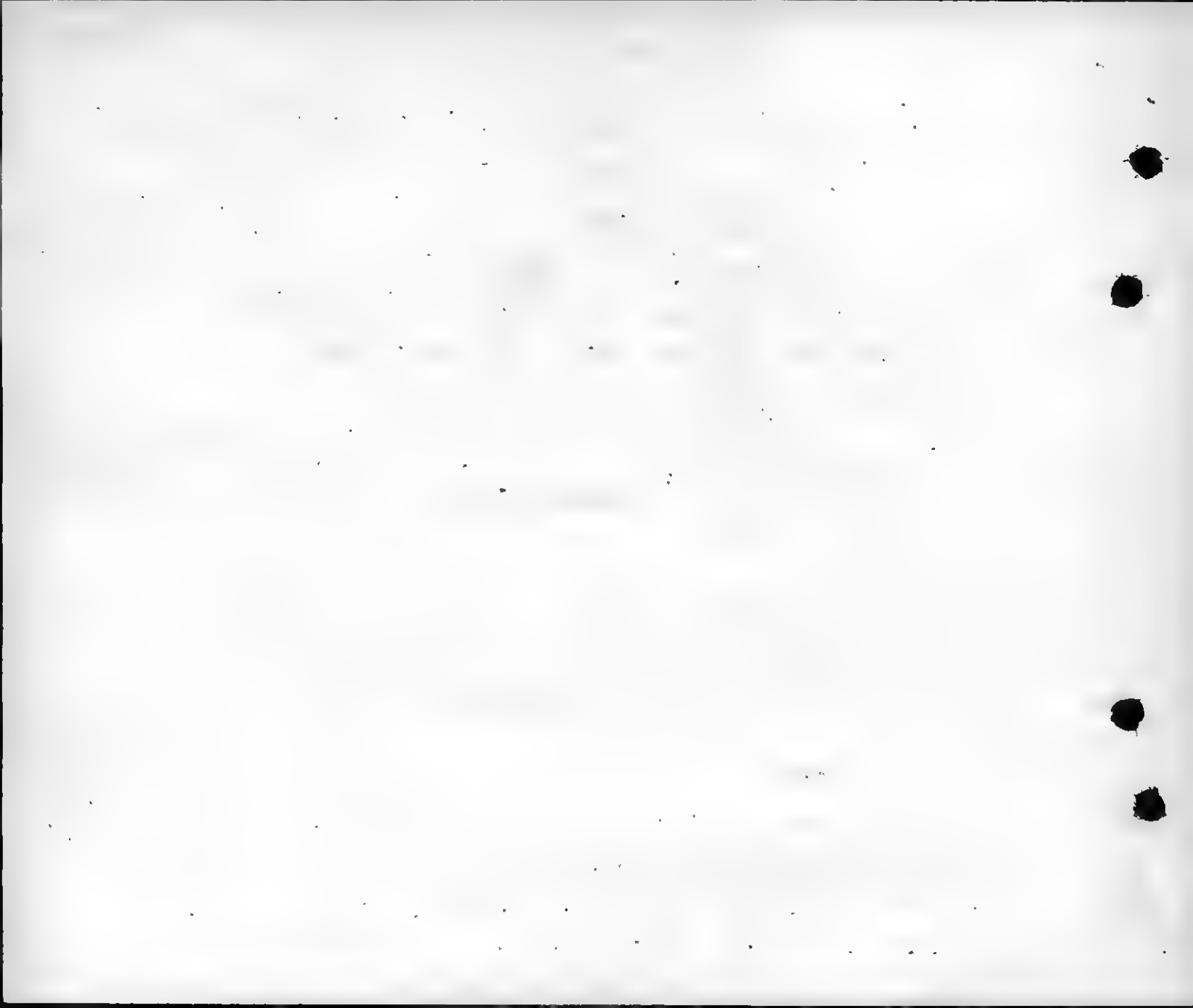
1904

## 6923 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>133 Grafton St.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Caggiano</u>		4. DATE OF DEATH <u>June 16 1959</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR <u>6</u> Months <u>29</u> Days <u>6</u> Hours <u>1</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Supv. U.A.</u>	
11. BIRTHPLACE (State or foreign country) <u>Boston - MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GAETANO CAGGIANO</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Wife</u>		Address <u>Same as Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: <u>430.0</u> IMMEDIATE CAUSE (a) <u>Subacute bacterial endocarditis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>Several months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/1/59</u> , 19 <u>59</u> , to <u>6/15/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>10:00 PM 6/15/59</u> and that death occurred at <u>10:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr Joseph Kenrick</u>		ADDRESS (Street, city or town, state) <u>6450 Wisconsin Ave, Bethesda Md</u>	
PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u>		DATE SIGNED <u>6/16/59</u>	
22a. BURIAL, CREMATION, or TRANSIT <u>Burial - Transit</u>		22b. DATE THEREOF <u>6-20-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery.</u>		22d. LOCATION (City, town, or county) (State) <u>Malden, Mass.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Md.</u>	
24a. REC'D BY REGISTRAR <u>JUN 19 '59</u>		24b. REGISTRAR'S SIGNATURE <u>William S. House</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral home. The attending physician and completed certificate has been signed by the attending physician and completed. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6924 CERTIFICATE OF DEATH

Reg. Dist. No.

06891

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Wash., D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x</u>	
c. LENGTH OF STAY IN 1b <u>1 week</u>		d. STREET ADDRESS <u>3610 M. ...</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>...</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>J. C.</u> Middle <u>Kennedy</u> Last <u>Campbell</u>		4. DATE OF DEATH Month <u>6</u> Day <u>15</u> Year <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-27-1870</u>
9. AGE (In years lost birthday) <u>88</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>...</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>...</u>	
11. BIRTHPLACE (State or foreign country) <u>...</u>		12. CITIZEN OF WHAT COUNTRY? <u>...</u>	
13. FATHER'S NAME <u>...</u>		14. MOTHER'S MAIDEN NAME <u>...</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>...</u>	
17. INFORMANT <u>...</u>		Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, bilateral</u> 400.0 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Debility from pyelonephritis</u> DUE TO (c) <u>and advanced arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>14 days</u> <u>4 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <u>...</u> p. m. Month <u>...</u> Day <u>...</u> Year <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept</u> <u>1956</u> to <u>June</u> <u>1959</u> , that I last saw the deceased alive on <u>June 14</u> , 1959, and that death occurred at <u>7:40 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>...</u> DATE SIGNED <u>6-15-59</u>			
ACTUAL SIGNATURE <u>James E. Gannon</u> M.D. <u>3141 34th St NW</u>		PHYSICIAN'S NAME (Type) <u>JAMES A. GANNON, JR.</u> <u>Washington D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>...</u>	22b. DATE THEREOF <u>June 18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Congressional</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest A. ...</u> ADDRESS <u>4748-Wis ave Washington D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u>			



1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

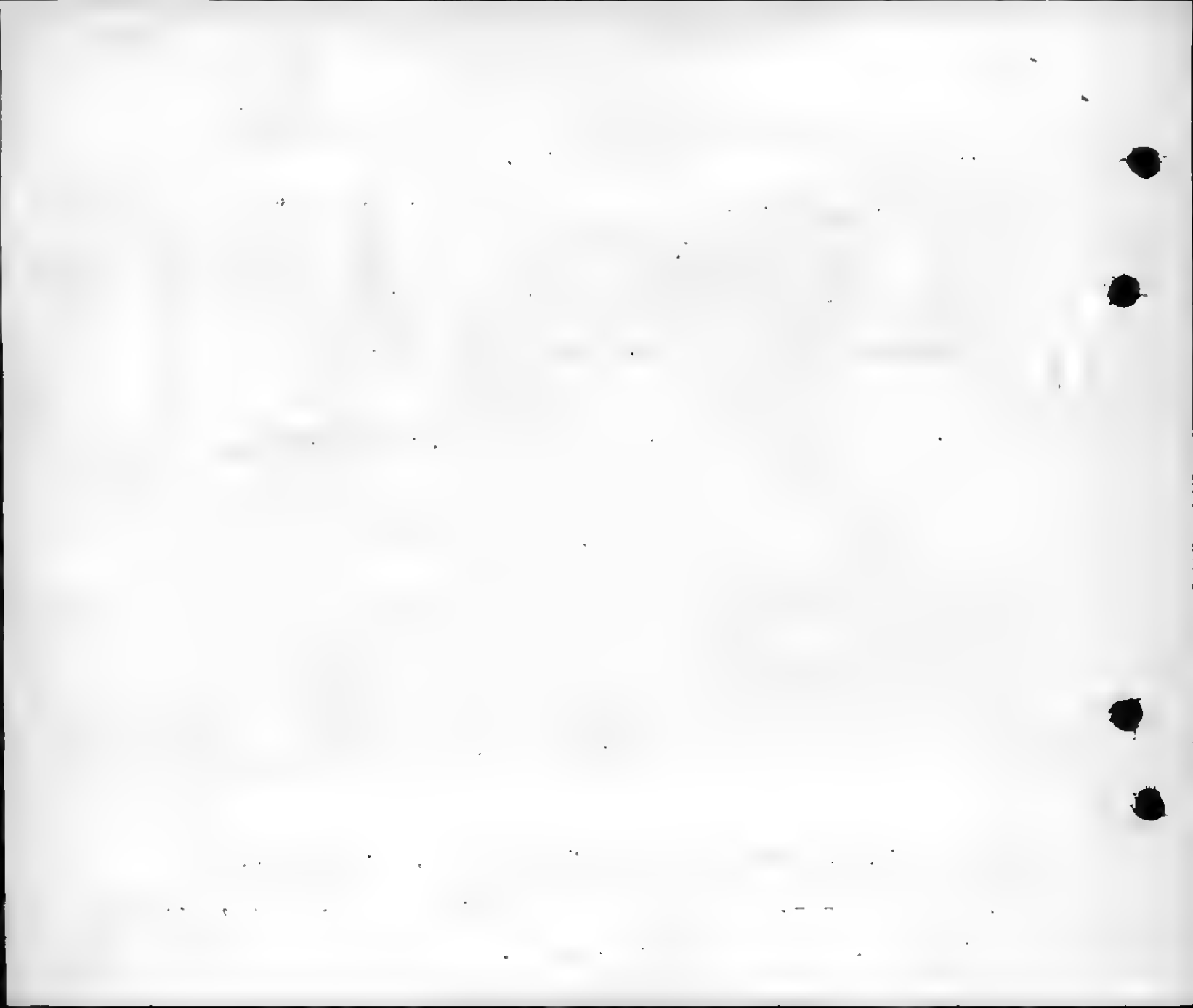
6925 CERTIFICATE OF DEATH

06892  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>3712 Kenilworth Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDITH M. CAREY</b>		4. DATE OF DEATH <b>June 2, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 3, 1876</b>
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR <b>4</b> Months <b>29</b> Days	11. IF UNDER 24 HRS <b>19</b> Hours <b>59</b> Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>New York</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>? Cleland</b>	
14. MOTHER'S MAIDEN NAME <b>Ellen ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Willard F. Carey-Item# 2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Colon</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 27, 1959</b> to <b>6/2/59</b> that I last saw the deceased alive on <b>6/1/59</b> , and that death occurred at <b>5:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>W. T. Joyce</b> M.D.			
PHYSICIAN'S NAME (Type) <b>W. T. Joyce 8106 Maple Ridge Avenue, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

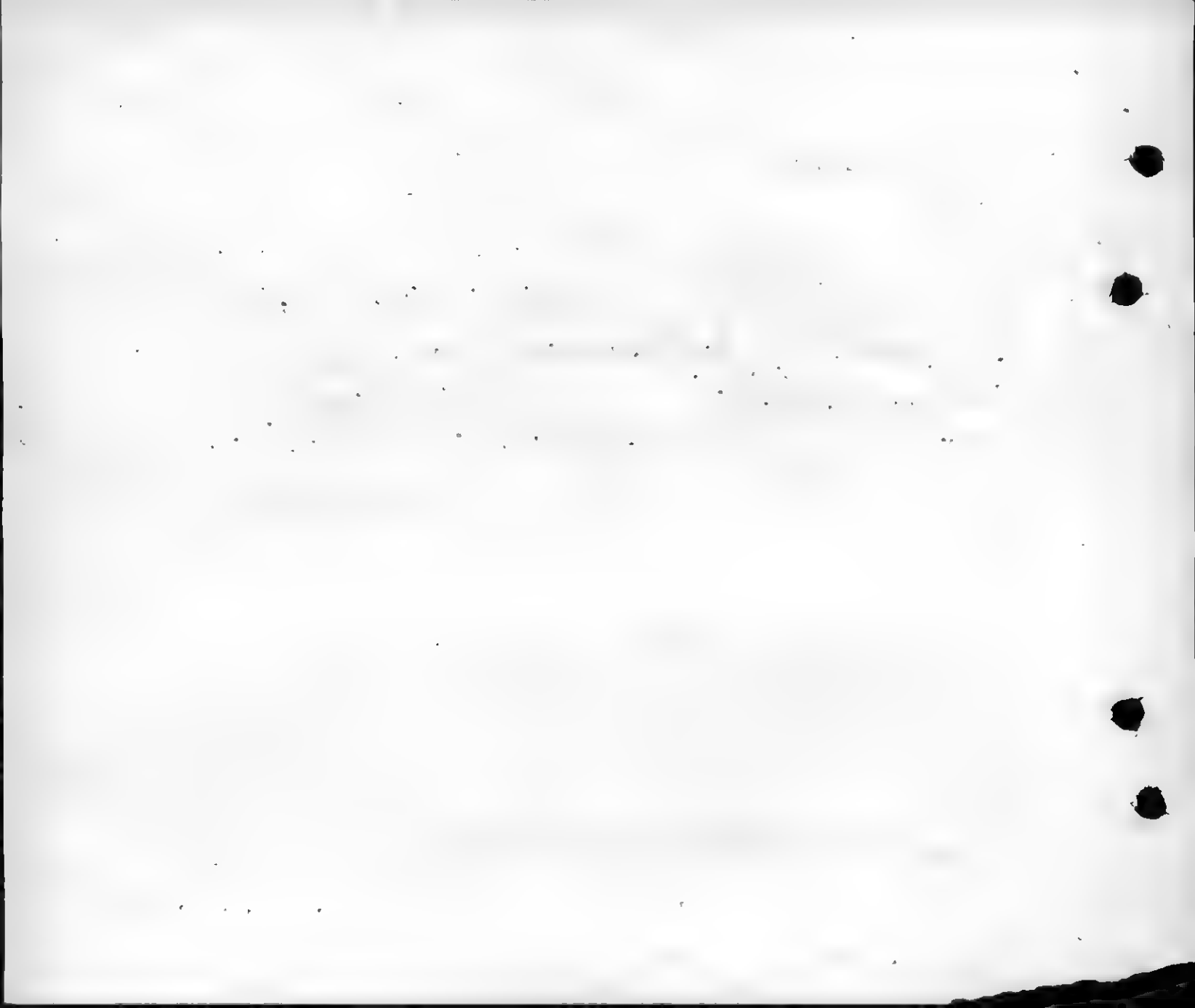
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6926 CERTIFICATE OF DEATH

06893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 15 <b>21</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>	
f. STREET ADDRESS <b>Box 53</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Claude</b> Middle <b>O</b> Last <b>Carlisle</b>		4. DATE OF DEATH Month <b>June</b> Day <b>8</b> Year <b>19 59</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-17-94</b>
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>21</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>James Carlisle</b>		14. MOTHER'S MAIDEN NAME <b>Susie Carter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>219-01-7884</b>	
17. INFORMANT <b>Fannie L. Carlisle</b>		Address <b>Same Wife</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombosis of the basilar artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Hypertensive cardio-vascular disease</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis of the kidney</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/7</b> , 19 <b>59</b> , to <b>6/8</b> , 19 <b>59</b> ; that I lost saw the deceased alive on <b>6/8</b> , 19 <b>59</b> , and that death occurred at <b>7:35 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert Young</b>		ADDRESS (Street, city or town, state) <b>Bethesda, Md</b>	
PHYSICIAN'S NAME (Type) <b>4740 Bradley Blvd. Bethesda Md</b>		DATE SIGNED <b>6/10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCAT ON (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kruza</b>	



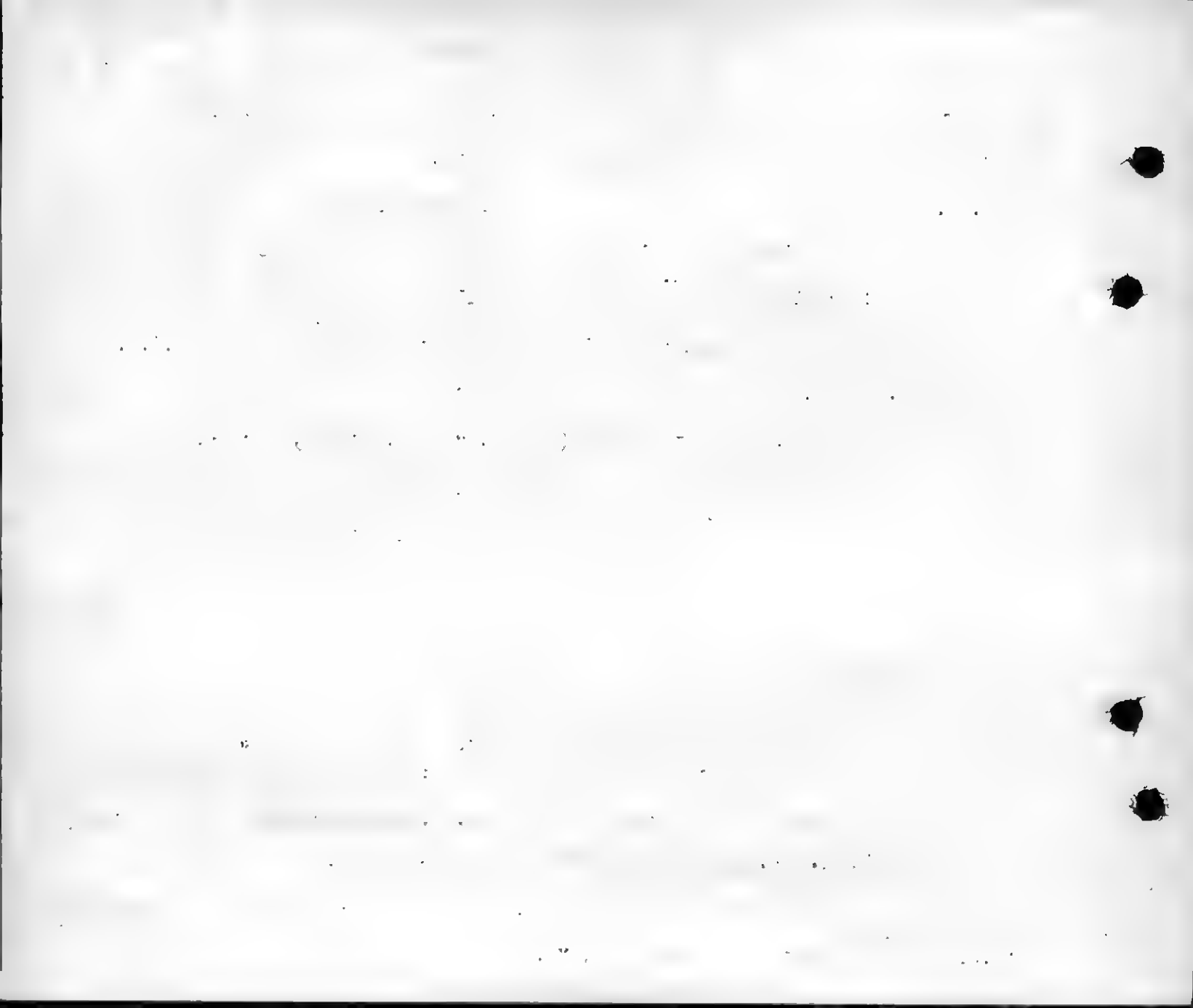
## 6927 CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>97 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Bethesda</b> d. STREET ADDRESS <b>9525 Milstead Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Clarence Clifton CARSON</b>		4. DATE OF DEATH Month Day Year <b>June 18 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-17-04</b>
9. AGE (In years lost birthday) yrs <b>54</b>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Watchmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchandising</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George W. CARSON</b>		14. MOTHER'S MAIDEN NAME <b>Annie Jones</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>3/42 to 12/43 577-34-6155</b>	
INFORMANT Address <b>(W) Mrs. Ruby B. Carson, same as item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>162.1 Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Bronchogenic Carcinoma</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>8 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 13</b> , 19 <b>59</b> , to <b>June 18</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 18</b> , 19 <b>59</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 6-19-59</b>			
ACTUAL SIGNATURE <b>Douglas R. Koth</b> M.D.		U. S. Naval Hospital	
PHYSICIAN'S NAME (Type) <b>Douglas R. KOTH, LT MC, USN</b>		Bethesda, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-22-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Humphrey</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Clinton L. Hume</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



CERTIFICATE OF DEATH

116895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>4X 4 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSP.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON GROVE</b> d. STREET ADDRESS <b>WASHINGTON GROVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>JOHN ERNEST CATOR</b>			4. DATE OF DEATH Month Day Year <b>JUNE 22 19 59</b>				
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/90</b>	9. AGE (In years last birthday) yrs <b>69</b>	10. IF UNDER 1 YEAR Months Days Hours Min. <b>69</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GARDENER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>A. GUDE &amp; SONS</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>			
13. FATHER'S NAME <b>EDWARD CATOR</b>			14. MOTHER'S MAIDEN NAME <b>MARTHA HENDERSON</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS</b> Address <b>OLNEY, MARYLAND</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adeno carcinoma of Prostate Gland</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Prostate Gland</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that I attended the deceased from <b>May 19 52</b> to <b>June 22 19 59</b> , that I last saw the deceased alive on <b>June 21 19 59</b> , and that death occurred at <b>2 26 a M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>JACK SCHUMACHER, M. D.</b> <b>6-22-59</b>							
ACTUAL SIGNATURE <b>JACK SCHUMACHER, M. D.</b> PHYSICIAN'S NAME (Type) <b>JACK SCHUMACHER, M. D.</b> <b>GAITHERSBURG, MARYLAND</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>June 25, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Potomac Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ed. G. Kraus</b>		ADDRESS <b>316 E Diamond Gaithersburg, Md</b>		24a. REC'D BY REGISTRAR <b>JUN 24 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 12 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

6929

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived: If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>27 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Bernard</u> Middle <u>Cavanaugh</u> Last <u>Cavanaugh</u>		4. DATE OF DEATH Month <u>6</u> - Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 26, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>13</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Martin T. Cavanaugh</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ganey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mary E. Cavanaugh</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Shock</u> DUE TO <u>Abdominal hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Shot gun wound in abdomen</u> DUE TO <u></u> (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>27 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Self-inflicted shot gun wound</u>	
20c. TIME OF INJURY Month, Day, Year <u>3:50 p.m. 6-8-59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Rockville</u> (County) <u>Montg</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Frank J. Broschaw</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschaw</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22b. DATE THEREOF <u>6-12-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Rockville, Maryland</u>		(State) <u></u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>DATE 12 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hough</u>	

DATE SIGNED

6-9-59





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06897

6930

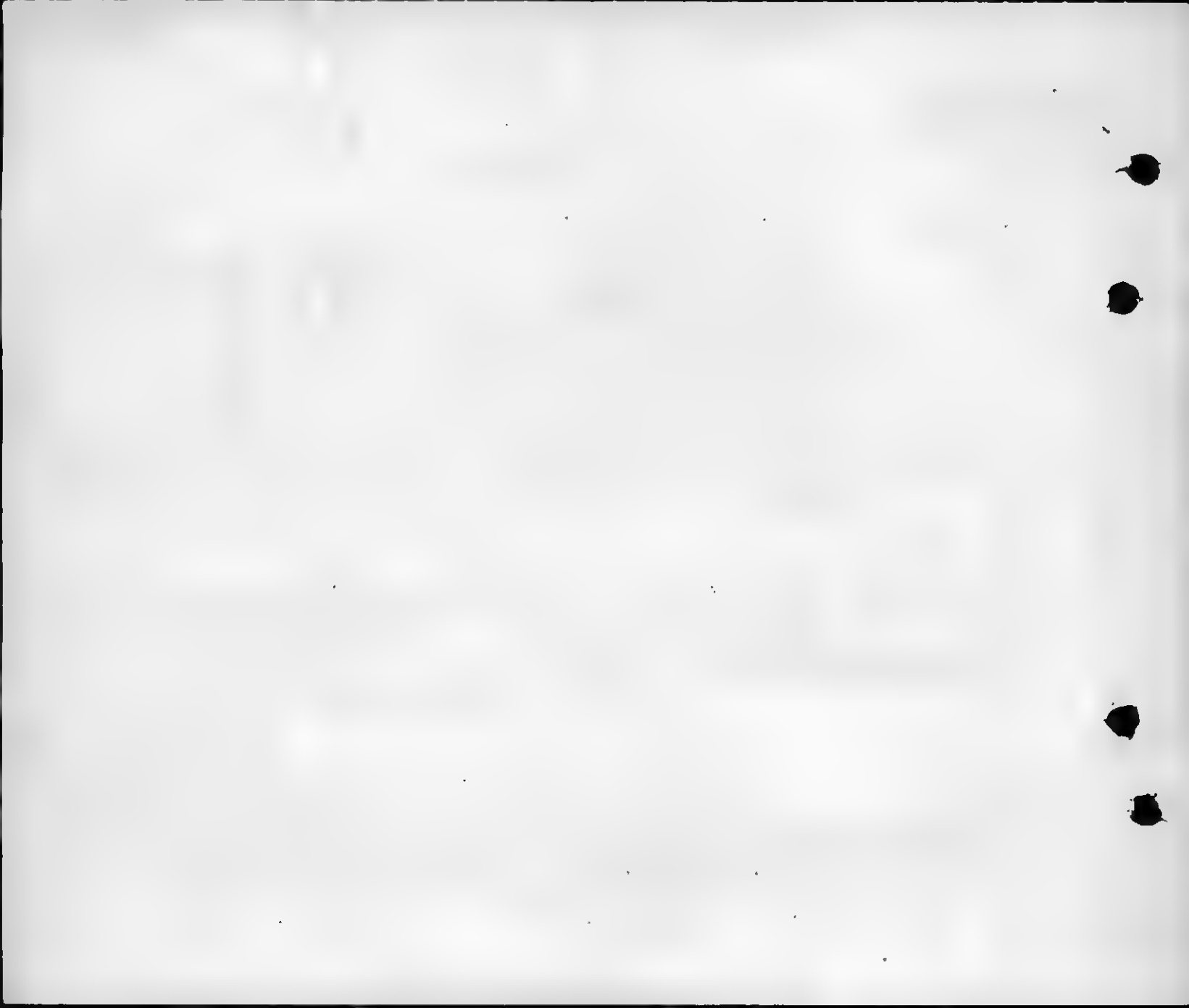
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>49 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Ontario, Canada</u> b. COUNTY <u>Toronto</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Toronto</u> d. STREET ADDRESS <u>26 Madison Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Marion Mary Chernick</u>			4. DATE OF DEATH Month Day Year <u>June 24, 19 59</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1910</u>		9. AGE (In years lost, birthday) <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY <u>Canada</u> ✓
13. FATHER'S NAME <u>Ozarko Stanley</u>			14. MOTHER'S MAIDEN NAME <u>Christine Galet</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>	17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia and Shock</u> <u>1957</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Urinary Tract Infection</u> DUE TO (c) <u>Adenocortical Carcinoma with Cushing's Syndrome</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15 hours</u> <u>72 hours</u> <u>2 Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May 6, 1959</u> to <u>June 24, 1959</u> , that I last saw the deceased alive on <u>June 24, 1959</u> and that death occurred at <u>11:05 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>6-25-59</u> <u>The National Institutes of Health</u> <u>Bethesda 14, Maryland</u>					
ACTUAL SIGNATURE <u>Richard H. Moy</u> M.D.		PHYSICIAN'S NAME (Type) <u>Richard H. Moy, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit 6/26/59</u>		22b. DATE THEREOF <u>6/26/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Toronto, Canada</u>	
22d. LOCATION (City, town, or county) (State) <u>Ontario, Canada</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

46898

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Kensington, Montgomery Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington, Bethesda Station</u> 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Chase</u>		d. STREET ADDRESS <u>14 West Annapolis St.</u>	
3. NAME OF DECEASED (Type or print) <u>Anne</u> First <u>Elizabeth</u> Middle <u>Chapin</u>		4. DATE OF DEATH Month <u>6</u> Day <u>28</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1915</u>
9. AGE (In years last birthday) <u>43</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>8</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WARREN CHATE</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Ragan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443X Cardiac failure, congestive</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <u>Hypertensive arteriosclerotic disease with cerebral accident + paralysis, legs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>16 mos.</u> <u>15 yrs.</u> <u>10 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 1958</u> to <u>June 28, 1959</u> that I last saw the deceased alive on <u>June 27, 1958</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip H. Varner</u>		DATE SIGNED <u>6-28-59</u>	
PHYSICIAN'S NAME (Type) <u>Philip H Varner</u>		ADDRESS (Street, city or town, state) <u>10,620 Ga. Ave., Silver Spring, Md.</u>	
22a. BURIAL, CREMATION, <u>BURIAL</u> (Specify)	22b. DATE THEREOF <u>7/1/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rockville Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rockville, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Bethesda, Maryland</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>		DATE <u>JUL 2 '59</u>	

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6932

CERTIFICATE OF DEATH

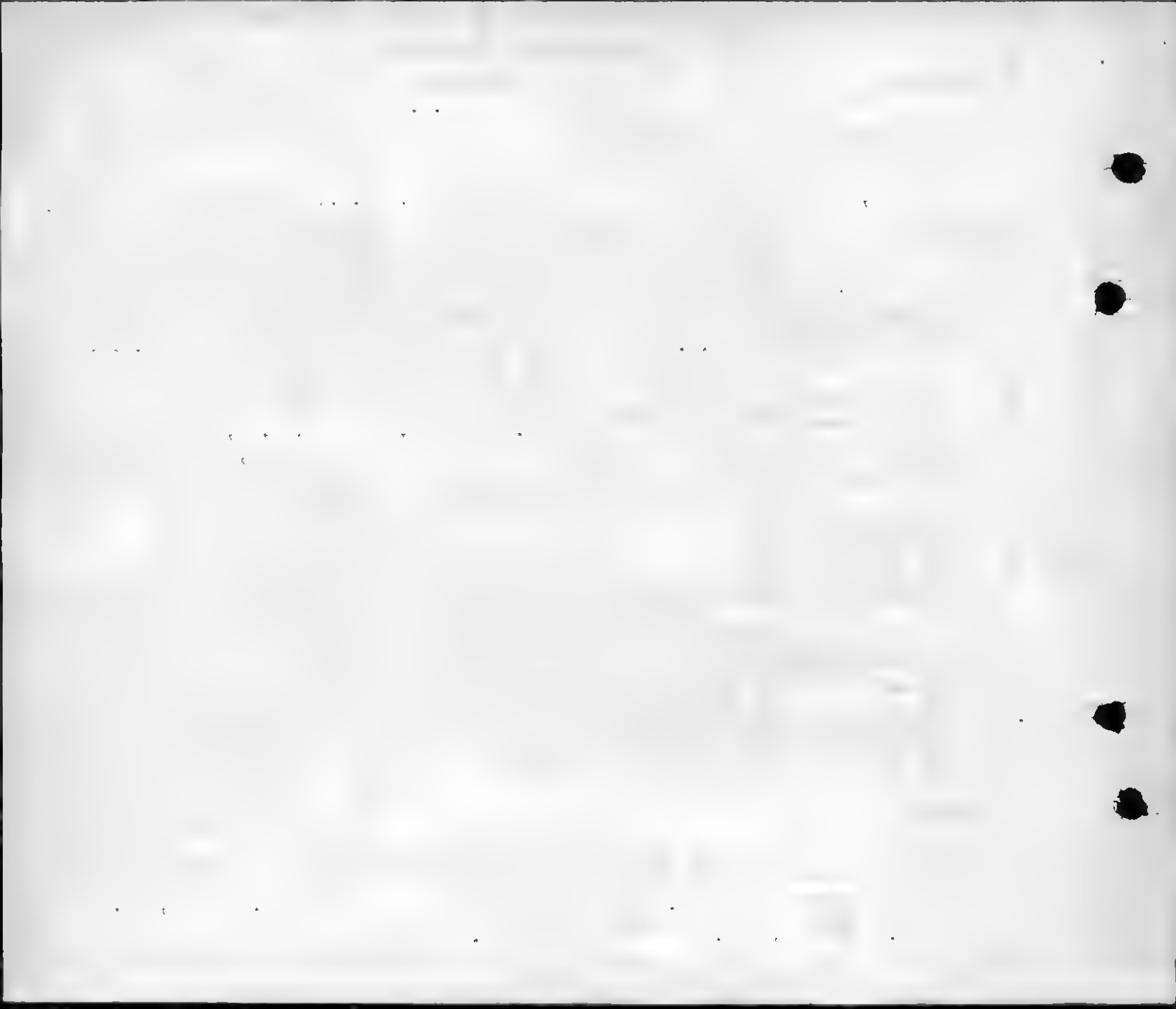
46899

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Johnson's Nursing Home</b>				d. STREET ADDRESS <b>1244 E St., N.E.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILBER</b> Middle <b>AUSTIN</b> Last <b>COPELAND</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/26/76</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer (retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Printing Office</b>		11. BIRTHPLACE (State or foreign country) <b>MICHIGAN</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>unknown COPELAND</b>				14. MOTHER'S MAIDEN NAME <b>SARAH MITCHELL</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>yes</b>		17. INFORMANT <b>Mrs. Robert M. Johnson, R.#1, Box 224</b> <b>Boyd's, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4-11</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 30, 1959</b> , to <b>June 26, 1959</b> , that I last saw the deceased alive on <b>June 25, 1959</b> , and that death occurred at <b>11:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10111 Colesville Rd. Silver Spring, Md.</b> DATE SIGNED ACTUAL SIGNATURE <b>A. F. Thibadeau</b> M.D. <b>10111 Colesville Rd. Silver Spring, Md.</b> PHYSICIAN'S NAME (Type) <b>A. F. THIBADEAU</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		22b. DATE THEREOF <b>6/29/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Mausoleum</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Geo. County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use at the burial-transit permit. Then please remove carbon page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

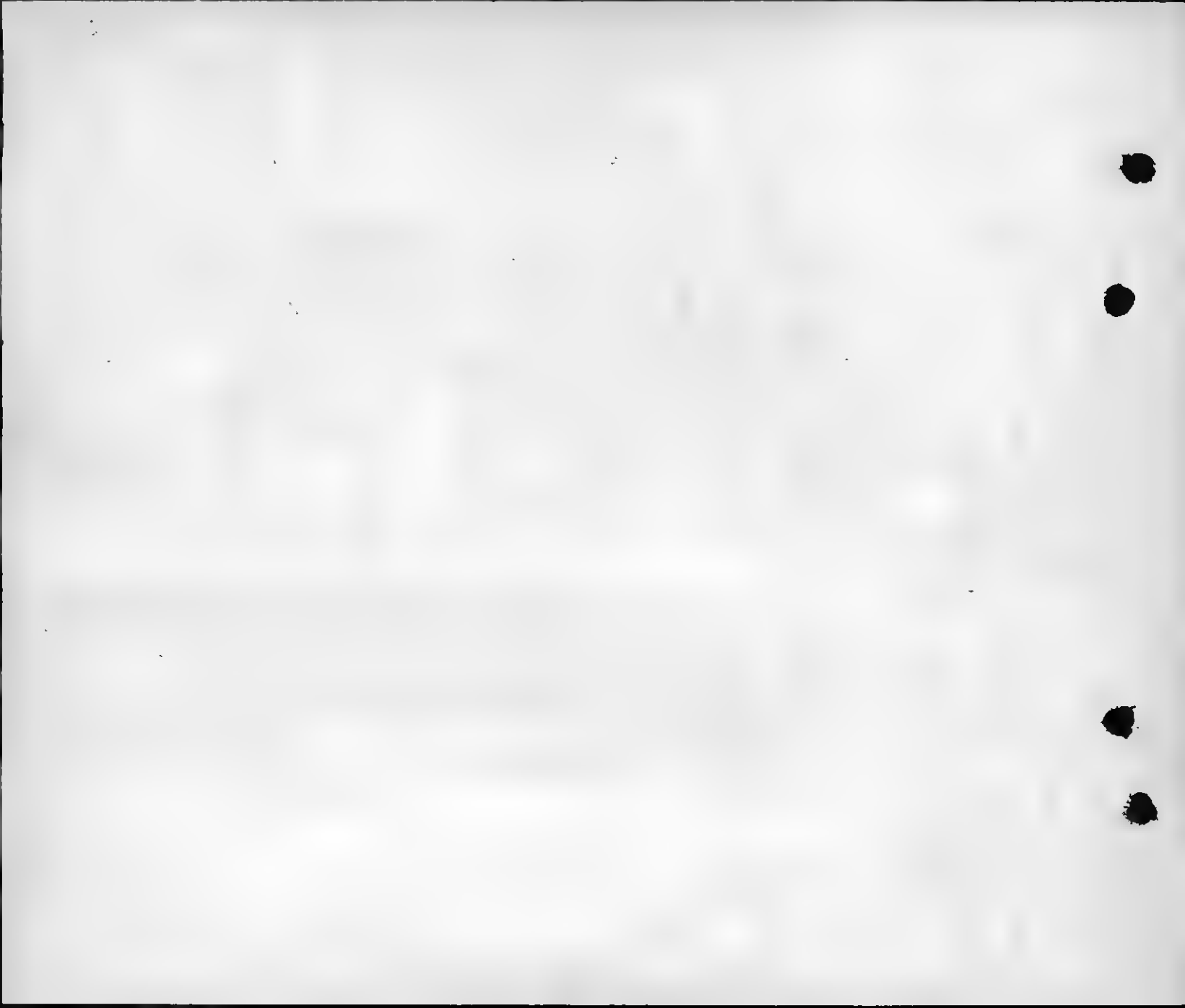
6933

## CERTIFICATE OF DEATH

06900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Rockville</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waverly Sanatorium</u>				d. STREET ADDRESS <u>7507 Arlington Dr</u>			
3. NAME OF DECEASED (Type or print) <u>Jessie</u> First <u>H.</u> Middle <u>Craig</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 14 1874</u>	
9. AGE (In years lost birthday) <u>84</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John F. Hill</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Luthrie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Coris P. Allwine</u> Address <u>1411 Rockwell Pike</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Polar Pneumonia</u> DUE TO (b) <u>Cerebral Accident of 2 mos duration</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/16</u> , 19 <u>59</u> , to <u>6/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/28</u> , 19 <u>59</u> , and that death occurred at <u>6:25</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wheeler O. Huff</u>				ADDRESS (Street, city or town, state) <u>4529 Waph Ave, Bethesda, Md.</u>			
DATE SIGNED <u>—</u>				DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>—</u>				PHYSICIAN'S NAME (Type) <u>—</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill C.E.</u>		22d. LOCATION (City, town, or county) (State) <u>Shippensburg Pa</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Jones</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6934

## CERTIFICATE OF DEATH

06901

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> <u>3509 Stark Street</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Kensington Maryland.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Danilowicz</u> Last <u>Danilowicz</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5th</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 3<sup>RD</sup> 1884</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	9. AGE (In years last birthday) <u>75</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>POLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(UNKNOWN) DANILOWICZ</u>		14. MOTHER'S MAIDEN NAME <u>MARY (UNKNOWN)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or, unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>199-14-4172</u>	
17. INFORMANT <u>JOSEPH DANILOWICZ</u>		Address <u>3509 STARK ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF STOMACH</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October</u> , 19 <u>57</u> , to <u>June 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 4</u> , 19 <u>59</u> , and that death occurred at <u>5:14</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Everett</u>		ADDRESS (Street, city or town, state) <u>9400 CONN. AV. KENSINGTON</u>	
PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		DATE SIGNED <u>6/5/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-8-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>	22d. LOCATION (City, town, or county) (State) <u>Wheaton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Houlton</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>



6935

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

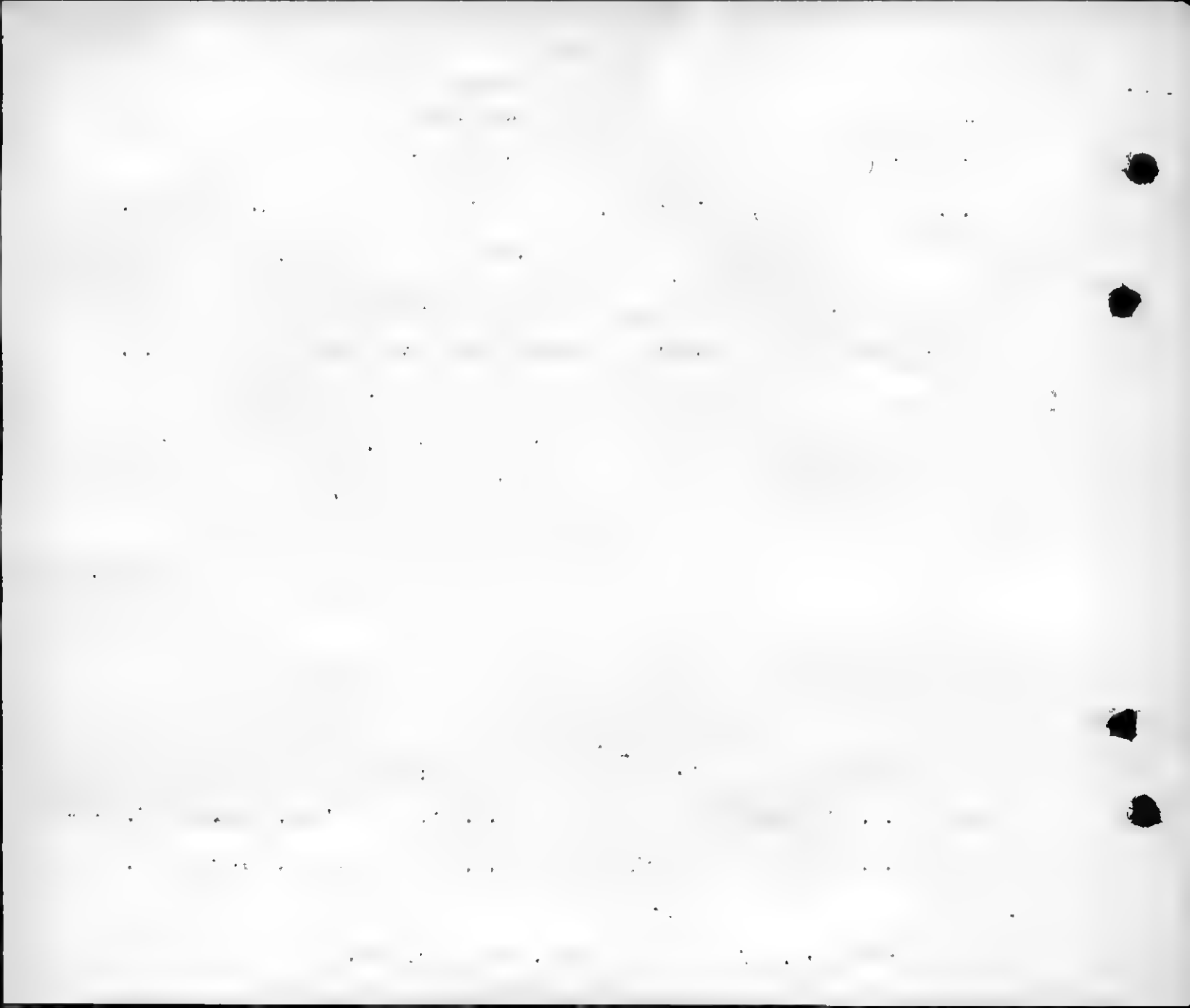
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>2 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>College Park</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cherry Hill Traylor Pk. #10 1st St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Evelyn Opal DAVIS</b>				4. DATE OF DEATH Month Day Year <b>June 3 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5 May 1932</b>	
9. AGE (In years last birthday) <b>27 yrs</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales clerk</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Opal Scott</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>(Husband) Hugh L. DAVIS Same as #2</b>		INFORMANT Address <b>Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tracheal Compression</b> <b>2043</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Mediastinal Infiltration</b> (c) <b>Acute Blastic Leukemia</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 June</b> , 19 <b>59</b> , to <b>3 June</b> , 19 <b>59</b> that I last saw the deceased alive on <b>3 June</b> , 19 <b>59</b> , and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above. F. H. O'Connell LT MC USN U.S. Naval Hospital, Bethesda Md. 6-4-59 F. H. O'Connell LT MC USN U.S. Naval Hospital, Bethesda Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-7-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Bonaventure</b>		22d. LOCATION (City, town, or county) (State) <b>Savannah Georgia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gasch's Francis Sons</b> ADDRESS <b>4739 Baltimore Ave. Hyattsville Md. 8 '59</b>				24a. REC'D BY REGISTRAR <b>Arthur S. Hanna</b>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Pages 1 and 2 should be filed with the funeral director, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers.

Page 4 may be retained by the hospital or the attending physician.

V5 A15 (4)  
15M 9/58



Items 18&amp;21 Film 245 7-22-59

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>District Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C. 4118</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium &amp; Hospital</b>		d. STREET ADDRESS <b>1400 Longfellow St. N.W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mildred</b> Middle <b>Mary</b> Last <b>Davis</b>		4. DATE OF DEATH Month <b>6</b> Day <b>5</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-1900</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Registered Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Miss</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>NATHAN DAVIS</b>		14. MOTHER'S MAIDEN NAME <b>Mollie Buck</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Washington Sanitarium</b>		Address <b>Takoma Park 12 M.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hematoma,</b> <b>703.0</b> DUE TO <b>right, frontal and</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Subarachnoid hemorrhage</b> DUE TO <b>both post-traumatic</b> (c) <b>aneurysm of right cerebral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and struck forehead and occiput - in Kitchen of home</b>	
20c. TIME OF INJURY Hour a. m. p. m. <b>May 24 1959</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Washington D.C.</b>
21. I certify that I attended the deceased from <b>29 May, 1959</b> to <b>5 June, 1959</b> that I last saw the deceased alive on <b>5 June, 1959</b> and that death occurred at <b>9:25 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert A. Mendelsohn M.D.</b>		DATE SIGNED <b>5 June 59</b>	
PHYSICIAN'S NAME (Type) <b>Robert A. Mendelsohn M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <b>6-9-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Washington D.C.</b>	22d. LOCATION (City, town, or county) (State) <b>St. Michael D.C.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEE FUNERAL HOME</b>		ADDRESS <b>300. 4th ST NE</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Robert S. Frank</b>	

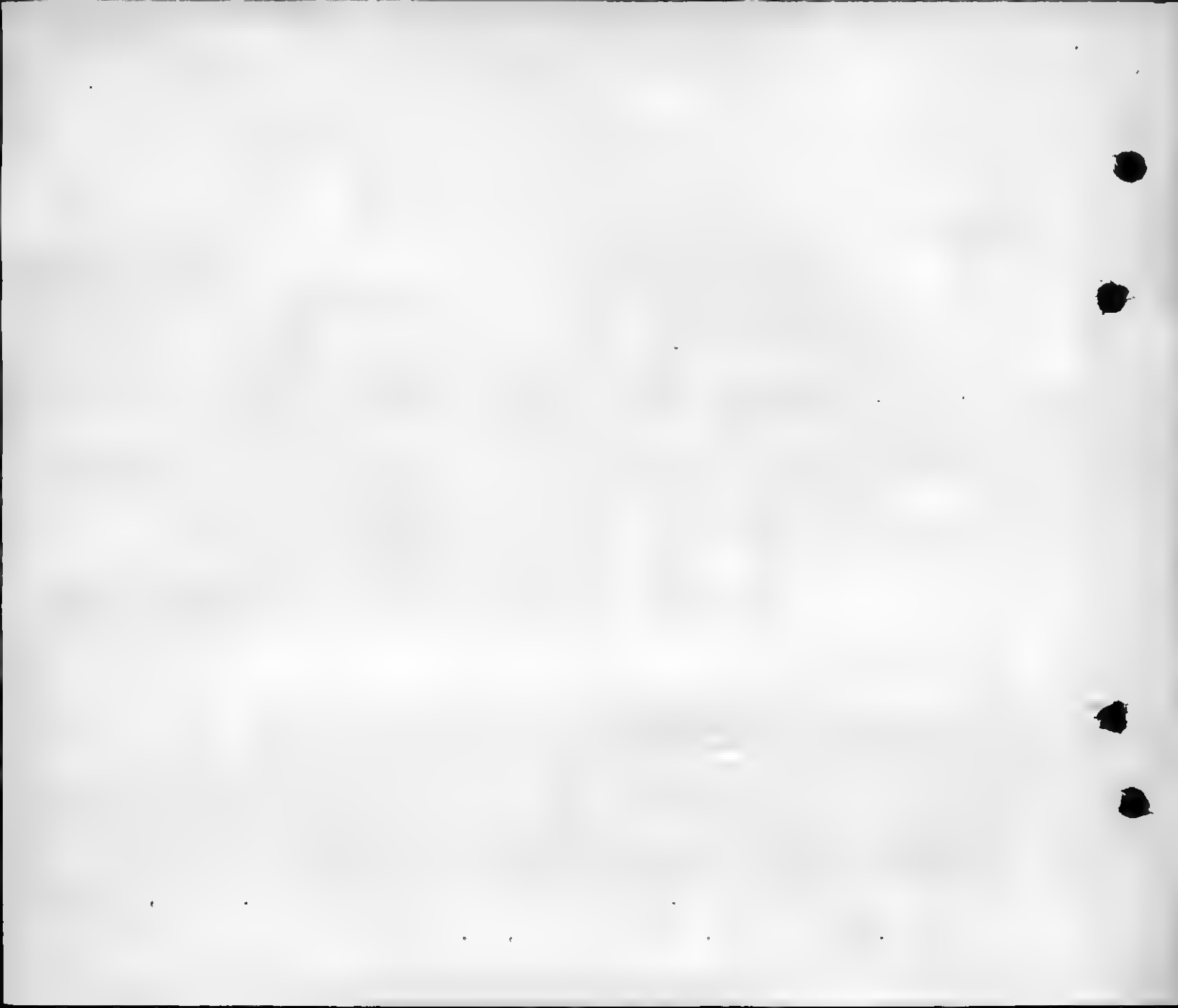
WATMAN DAVID

## 6877 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tekoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u>	
c. LENGTH OF STAY IN 1b <u>4 days</u>		d. STREET ADDRESS <u>8714 First Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>John</u> Last <u>Dickinson</u>		4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-98</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>6</u> Days <u>14</u> Hours <u>11</u> Min. <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>American Seale Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Fred H. Dickinson</u>		14. MOTHER'S MAIDEN NAME <u>BABETTE Wirth</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-01-7051</u>	
17. INFORMANT <u>Hospital Admitting Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage - upper G.I.</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Esophageal Varices</u> DUE TO (c) <u>Cirrhosis of the Liver</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>Unknown</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arricular Fibrillation</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>June 23, 1959</u> , that I last saw the deceased alive on <u>June 23, 1959</u> , and that death occurred at <u>11:50 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert Hare</u>		ADDRESS (Street, city or town, state) <u>7600 Carroll Ave. Takoma Park, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Robert A. Hare, MD.</u>		DATE SIGNED <u>6/23/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/25/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MARYLAND</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR <u>SILVER SPRING, MD.</u> DATE <u>JUN 25 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6937

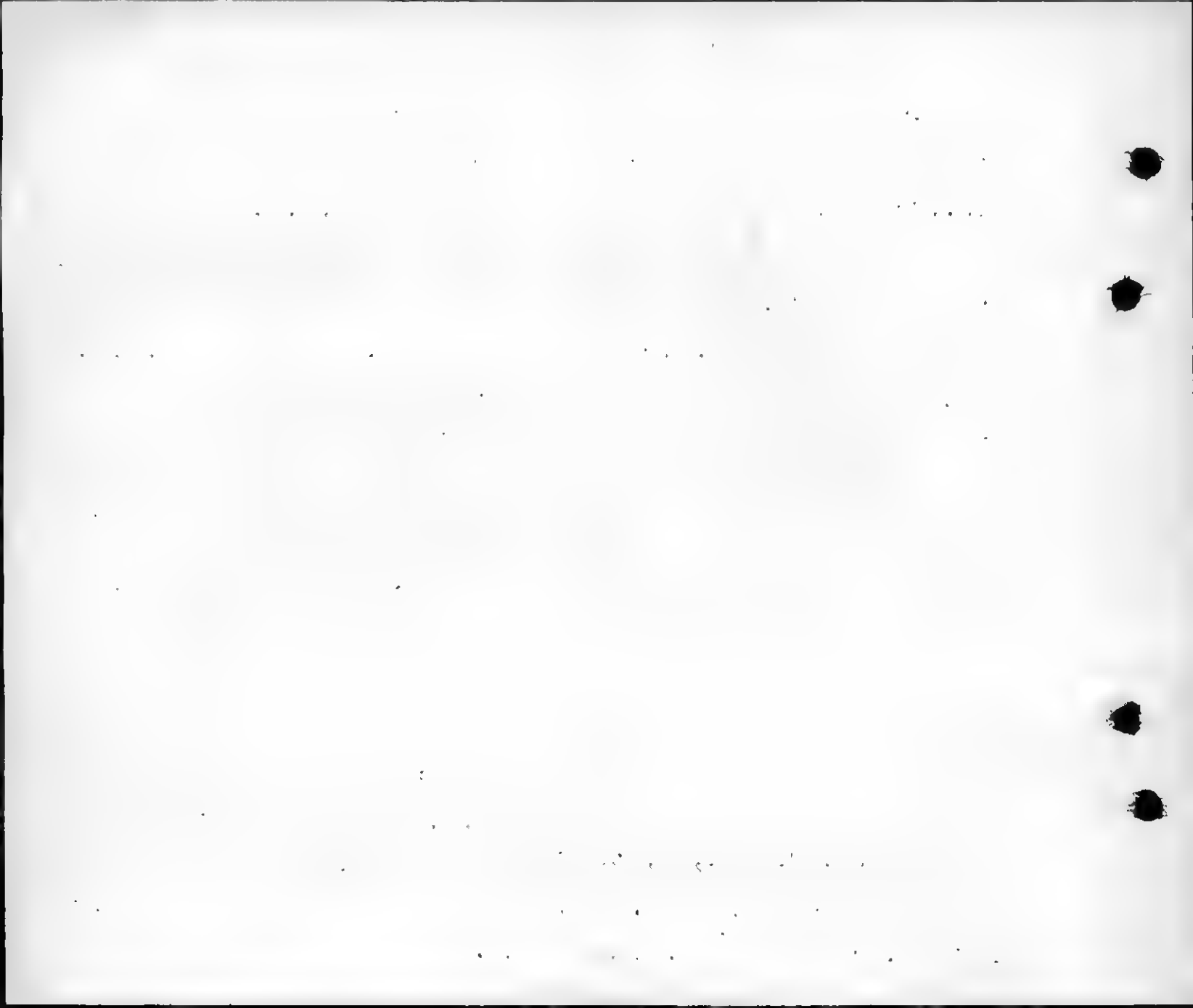
## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN lb <b>2 hours</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>2125 34th Street, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Francis DIETRICH</b>				4. DATE OF DEATH Month Day Year <b>June 29 1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-93</b>	9. AGE (In years last birthday) <b>65</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry DIETRICH</b>				14. MOTHER'S MAIDEN NAME <b>Anna SCHWAB</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT Address <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Poliomyelitis Edema</b> DUE TO (b) <b>Sec to ASD and Pneumonia</b> DUE TO (c) <b>Multiple Myeloma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>3 yrs</b> <b>3 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Bethesda</b>	(County) <b>Montgomery</b>	(State) <b>Maryland</b>		
21. I certify that I attended the deceased from <b>June 29</b> , 19 <b>59</b> , to <b>June 29</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 29</b> , 19 <b>59</b> , and that death occurred at <b>10:50 PM</b> , from the causes and on the date stated above. <b>F. H. O'Connell</b> ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NMMC</b> DATE SIGNED <b>6-30-59</b>							
ACTUAL SIGNATURE <b>F. H. O'CONNELL, LT, MC, USN</b>		M.D. <b>Bethesda, Maryland</b>					
PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LT, MC, USN</b>		<b>Bethesda, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7-2-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) <b>Arlington</b>	(State) <b>Virginia</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b> ADDRESS <b>Lee Funeral Home, 4th &amp; Mass. Ave. NE, Wash., DC</b>			24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6938

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. STATE <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>26 ROCKVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>		d. STREET ADDRESS <b>243 NORTH ADAMS STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BRUCE TERRY DIFFENDERFER</b>		4. DATE OF DEATH Month Day Year <b>JUNE 30 19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/1/57</b>	9. AGE (In years last birthday) <b>1</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min <b>9 29</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHILD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>TERRY BRUCE DIFFENDERFER</b>		14. MOTHER'S MAIDEN NAME <b>WANDA L. WOODWARD</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>HOSPITAL RECORDS OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> DUE TO <b>441X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bilateral Bronchopneumonia</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/29</b> , 19 <b>59</b> , to <b>6/30/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/30/59</b> , 19 <b>59</b> , and that death occurred at <b>12:50 A.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>6/30/59</b>					
ACTUAL SIGNATURE <b>L. I. Leal</b> M.D.					
PHYSICIAN'S NAME (Type) <b>L. I. LEAL, M. D.</b>		<b>GAITHERSBURG, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/30/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lee Memorial Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Woodway, Virginia</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		ADDRESS <b>Bethesda, Maryland</b>			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6939

## CERTIFICATE OF DEATH

06907

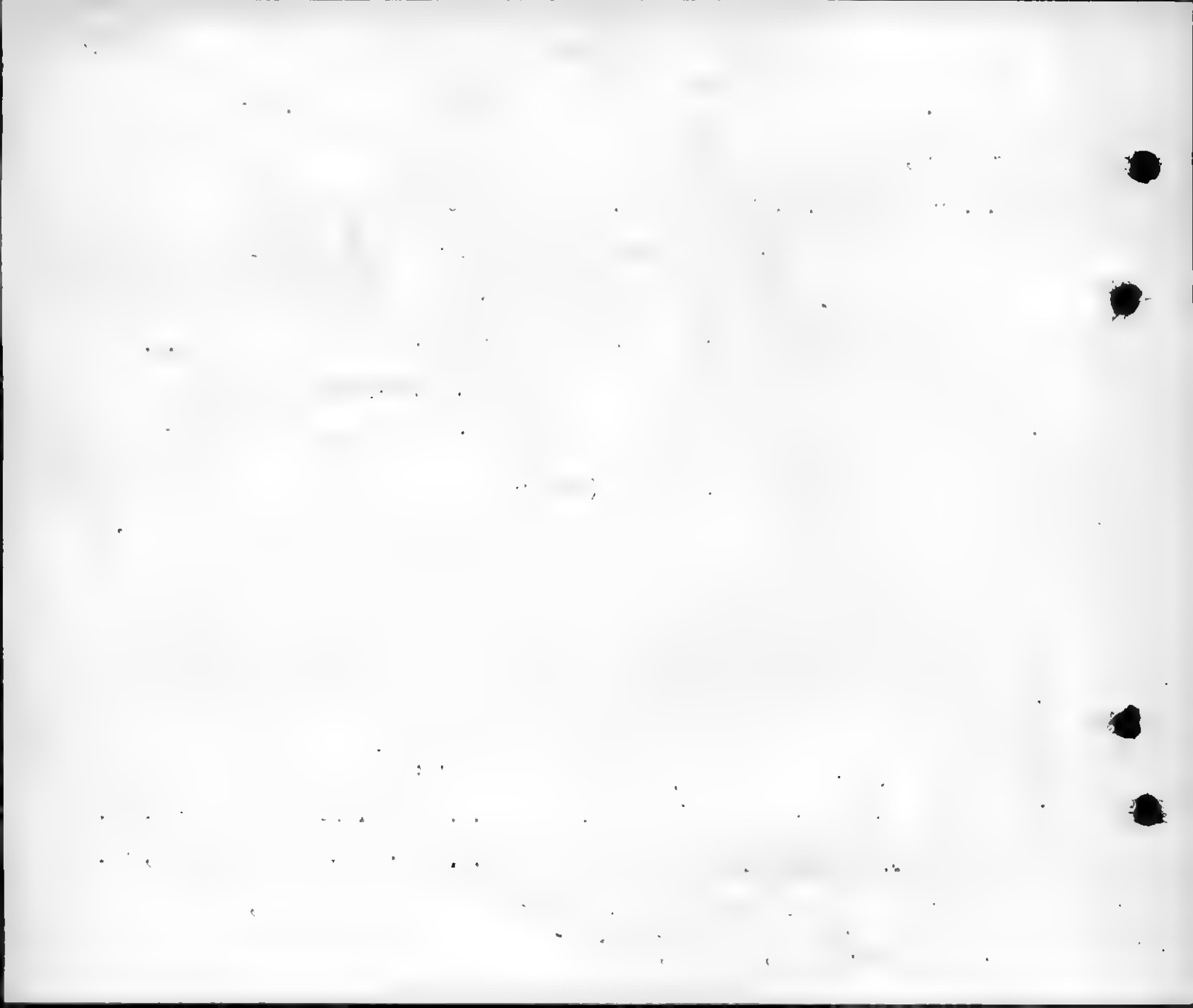
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> c. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>Town Creek Manor</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Wilma Marie Dinterman</b>				4. DATE OF DEATH Month Day Year <b>June 12 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4 February 1918</b>	
9. AGE (In years last birthday) <b>41</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stenographer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>		11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Herman Busacker</b>				14. MOTHER'S MAIDEN NAME <del>Walter Dinterman</del> <b>Jennie Waffer</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>(husband) Roger Alfred DINTERMAN Same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia (duration - one week)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10 June 19 59</b> to <b>12 June 19 59</b> , that I last saw the deceased alive on <b>12 June 19 59</b> , and that death occurred at <b>12:35 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>W. McFarland</i> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>U.S. Naval Hospital, Bethesda, Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. McFarland CDR MC USN</b>				ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>17 June 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Everly Funeral Home</i>				24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

Montgomery County Medical Examiner notified.

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06908

6940

## CERTIFICATE OF DEATH

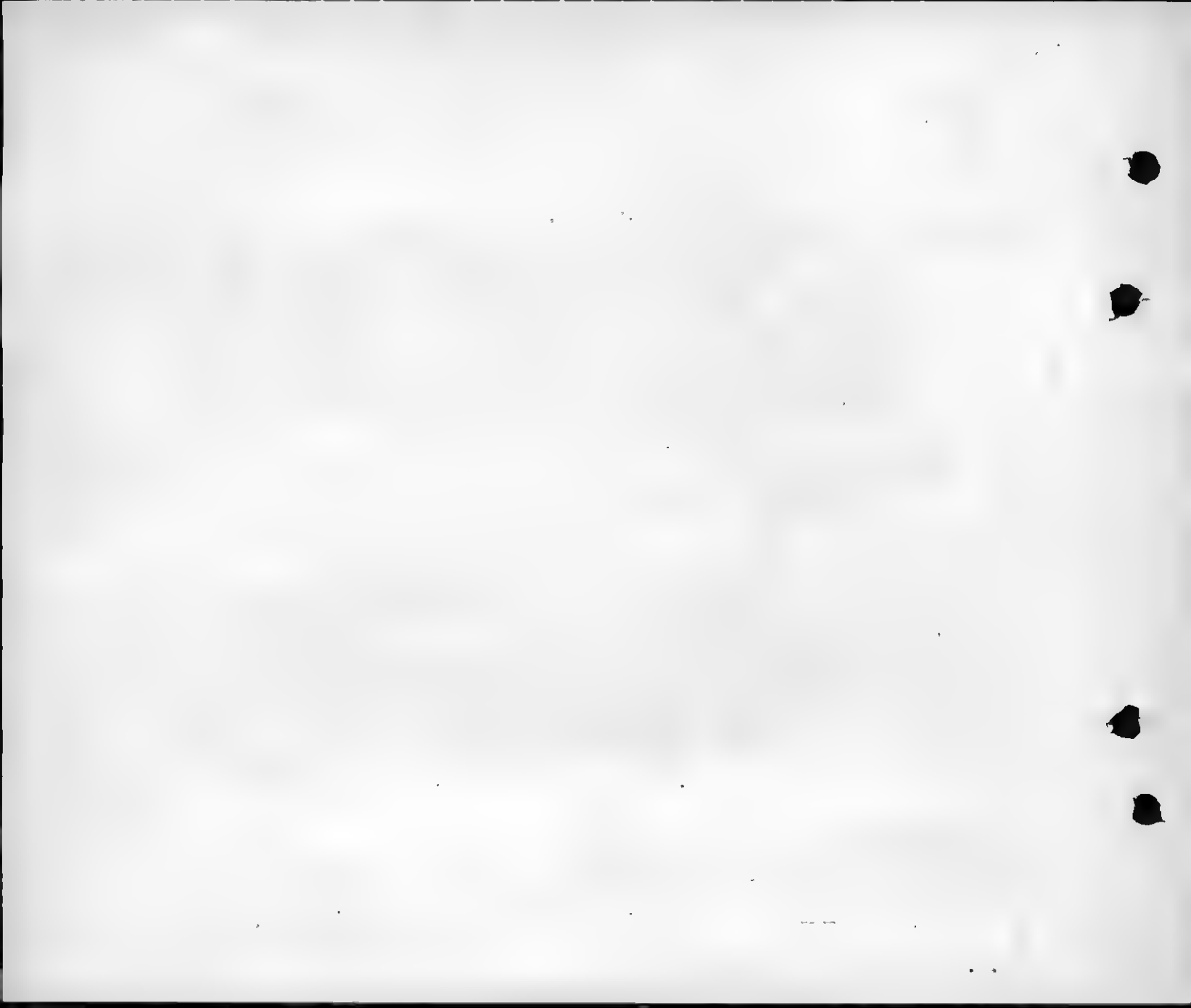
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HIGHLAND</b> 13X d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>AMELIA OLIVIA DISNEY</b>		4. DATE OF DEATH Month Day Year <b>JUNE 3 19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/71</b>
9. AGE (In years last birthday) <b>88</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>BOWIE JOHNSON</b>		14. MOTHER'S MAIDEN NAME <b>LOUANN THOMPSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CACHEXIA</b> <b>104X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CARCINOMA OF RECTUM</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>UREMIA DUE TO NEPHROSCLEROSIS</b>			INTERVAL BETWEEN ONSET AND DEATH <b>10 DAYS</b> <b>5 YEARS</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>19 46</b> to <b>JUNE 3</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>JUNE 3</b> , 19 <b>59</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>6/3/59</b>			
ACTUAL SIGNATURE <i>Charles S. Whitaker, M.D.</i> PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>		SANDY SPRING, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-5-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>	22d. LOCATION (City, town, or county) (State) <b>Highland, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 5 '59</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hauer</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6941 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06909

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>		c. LENGTH OF STAY IN 1b <b>35 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Echo</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>100 University Avenue</b>				d. STREET ADDRESS <b>100 University Avenue</b>			
3. NAME OF DECEASED (Type or print) <b>Coralie Livingston Bell Douglas</b>				4. DATE OF DEATH <b>June 21, 19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 3, 1875</b>	
9. AGE (In years last birthday) <b>83 yrs.</b>		10. IF UNDER 1 YEAR <b>83</b> Months <b>7</b> Days <b>18</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Hagerstown, Md.</b>	
13. FATHER'S NAME <b>Henry Bell</b>				14. MOTHER'S MAIDEN NAME <b>Ellen Ragan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Eloise D. Graham - Item #2-daughter</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxia</b> DUE TO <b>Inhalation of smoke + fumes</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>burning home</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2nd + 3rd degree burn of extremities, head + neck</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> <b>House fire</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year <b>2:15 p.m. 6-21 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Glen Echo Montg. Md.</b> (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Frank J. Broschart</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>FRANK J. Broschart</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>6-21-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Tran.-Bur.</b>		22b. DATE THEREOF <b>6/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR <b>JUN 24 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Huns</b>	



6878

## CERTIFICATE OF DEATH

06910

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admision) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>68 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>17 TAKOMA PARK.</u>	
f. STREET ADDRESS <u>6833 EASTERN AVE</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>ZILHA</u> Middle <u>MINNIE</u> Last <u>DOUGLAS</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>12</u> Year <u>1959</u>	
5. SEX <u>FE</u>	6. COLOR OR RACE <u>WH</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 24, 1858</u>
9. AGE (In years last birthday) <u>100</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>NEW YORK</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>? CHILDS.</u>		14. MOTHER'S MAIDEN NAME <u>(unknown by informant)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Willard R. Douglas (son)</u>		Address <u>(child)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis, generalized.</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>June</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 12, 1959</u> to <u>April 12, 1959</u> , that I last saw the deceased alive on <u>June 12, 1959</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William F. Simpson, Jr. M.D.</u>		DATE SIGNED <u>6/12/59</u>	
PHYSICIAN'S NAME (Type) <u>William F. Simpson, Jr.</u>		<u>Washington, D.C.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>June 15, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Arthur Walters</u>		ADDRESS <u>254 Carroll St NW DC</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 15 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



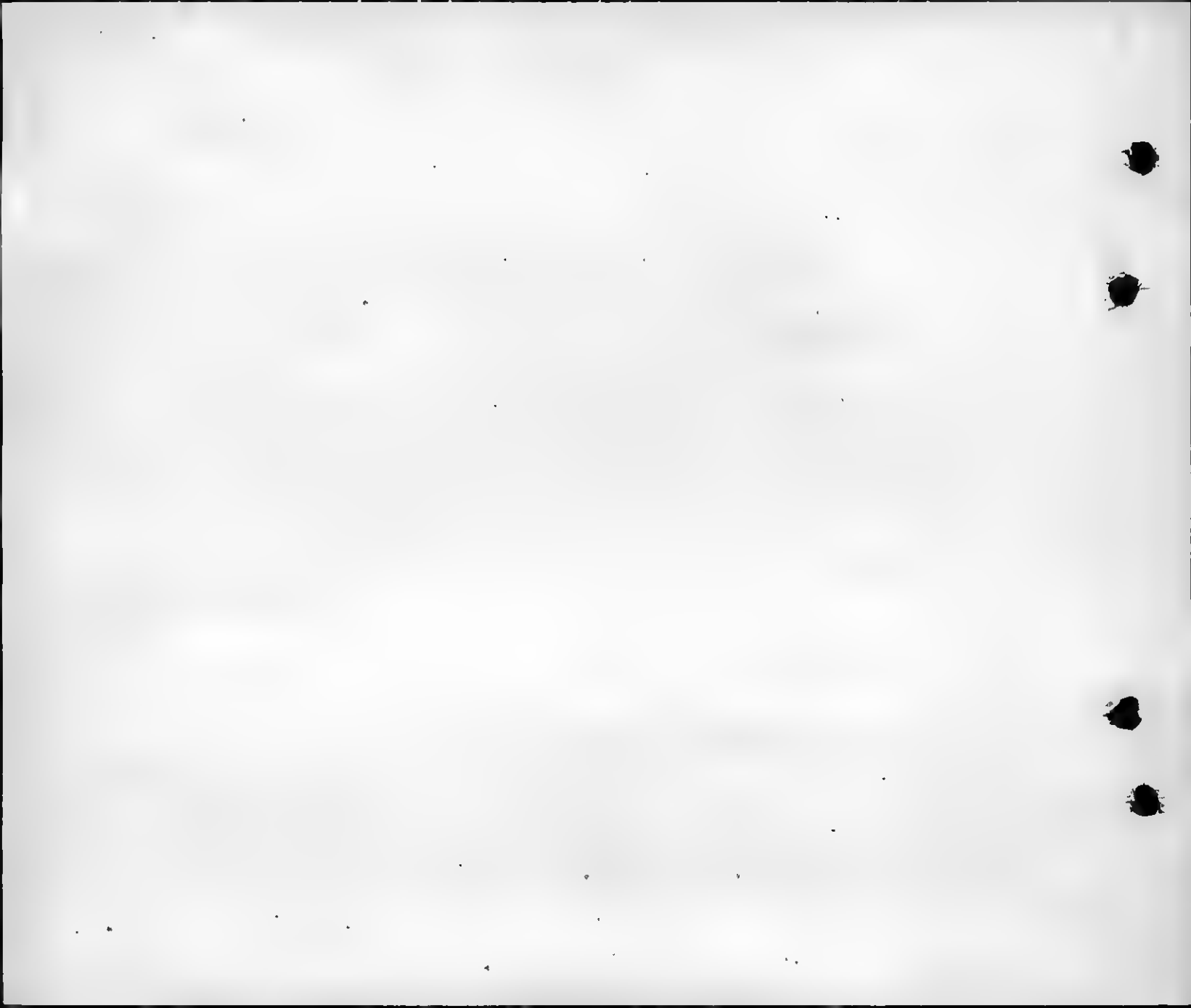
06912

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <b>MARYLAND</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LILLIAN AGNES DOWNS</b>				4. DATE OF DEATH Month Day Year <b>JUNE 30 19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/24/90</b>	
9. AGE (In years last birthday) yrs <b>68</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>	
12. CITIZEN OF WHAT COUNTRY <b>USA</b>							
13. FATHER'S NAME <b>ADAM MATULEWICH</b>				14. MOTHER'S MAIDEN NAME <b>JENNY NAGNORSKI</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>HOSPITAL RECORDS</b>			
Address <b>OLNEY, MARYLAND</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Secondary Anemia</b> DUE TO (c) <b>Metastatic Carcinoma of Uterus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1958</b> , to <b>June 30 1959</b> , that I last saw the deceased alive on <b>June 29 1959</b> , and that death occurred at <b>2:15 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6-30-59</b>							
ACTUAL SIGNATURE <b>Richard A. Yates, M.D.</b>							
PHYSICIAN'S NAME (Type) <b>RICHARD A. YATES, M. D.</b>		<b>OLNEY, MARYLAND</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>July 3, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brookeville</b>		22d. LOCATION (City, town, or county) (State) <b>Brookeville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Gray W. Barber</b>				ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 6 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knecht</b>			

**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and completed, it is filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6943

## CERTIFICATE OF DEATH

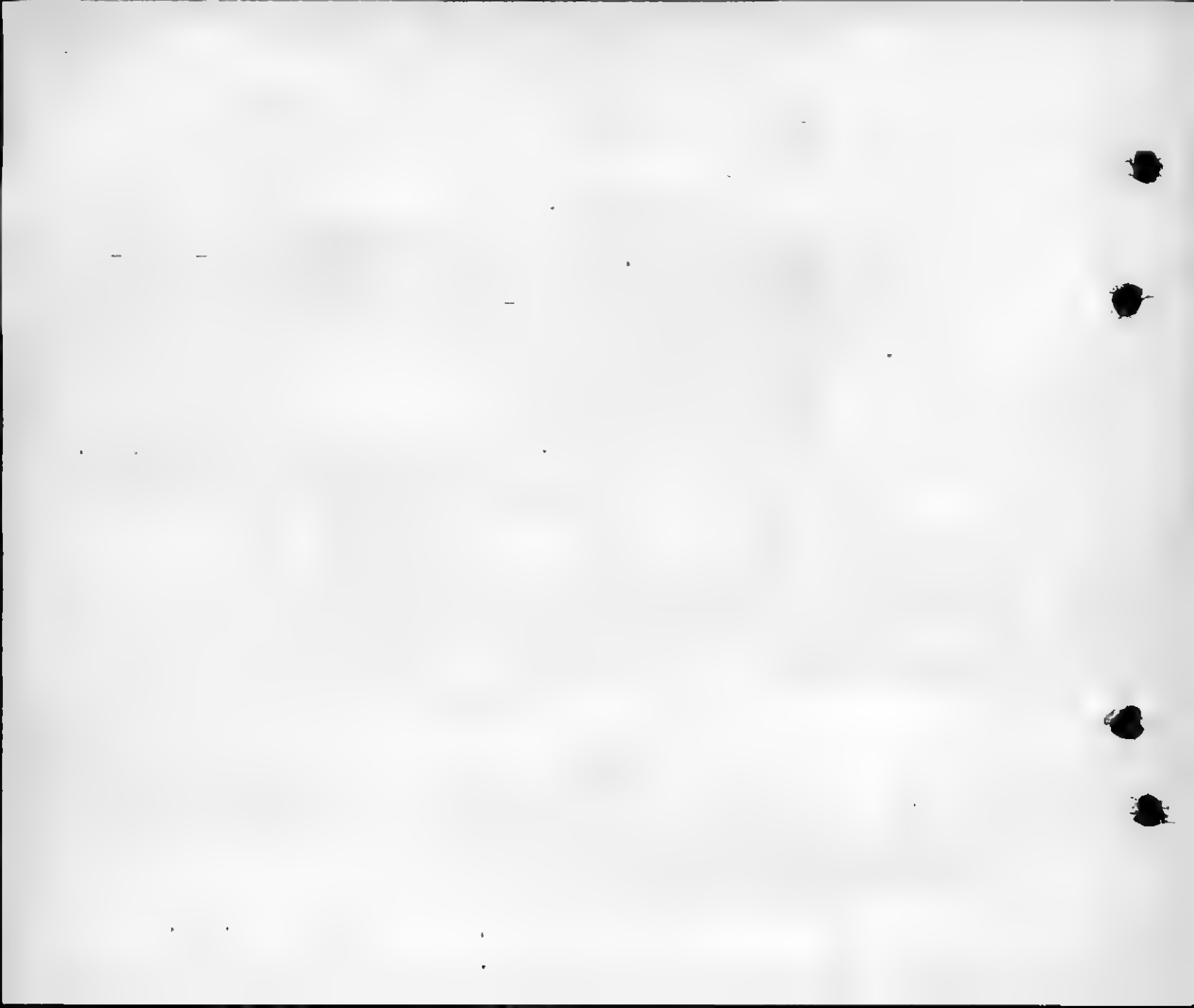
06911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admittance) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery County General Hosp.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Gaithersburg</b>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>R.</b> Last <b>Duvall</b>		4. DATE OF DEATH Month <b>6</b> - Day <b>29</b> - Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-96</b>
9. AGE (In years last birthday) yrs <b>63</b>		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hswf.</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>United States</b>	
13. FATHER'S NAME <b>John Raab</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>C. Vernon Duvall, Gaithersburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerotic cardiovascular disease</b> <b>260X</b> DUE TO <b>cardiovascular accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Diabetes mellitus</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b> <b>3 days</b> <b>25 days</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>12/15, 1946</b> , to <b>6/29, 1959</b> , that I last saw the deceased alive on <b>6/28, 1959</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James P. Kern</b> M.D.		ADDRESS (Street, city or town, State) <b>Damascus, Md.</b> DATE SIGNED <b>7/1/59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>7/2/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Moth.</b>	22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. McNamee</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
ADDRESS <b>Damascus, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from this certificate and placed in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6944

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Beth. Suburban</b>		e. STREET ADDRESS <b>9010 Bradford Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>Clifton E. Eldridge</b>		f. DATE OF DEATH <b>June 20, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mac. Naval Gun Factory</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Simeon Eldridge</b>		14. MOTHER'S MAIDEN NAME <b>Augusta Crosier</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Adelaid L. Eldridge</b>		Address <b>9010 Bradford Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1-2 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dissecting abdominal aortic aneurysm</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1948 to 20 June 1959</b> , that I last saw the deceased alive on <b>20 June 1959</b> , and that death occurred at <b>11:05 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		ADDRESS (Street, city or town, state) <b>9006 Colesville Rd</b> DATE SIGNED <b>6/24/59</b>	
PHYSICIAN'S NAME (Type) <b>William D. Aud</b>		<b>Silver Spring Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/23/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wesley L. ...</b>		ADDRESS <b>4812 9th Ave</b>	24a. REC'D BY REGISTRAR <b>JUN 25 '59</b>
		24b. REGISTRAR'S SIGNATURE <b>C. L. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WACO 112

6896

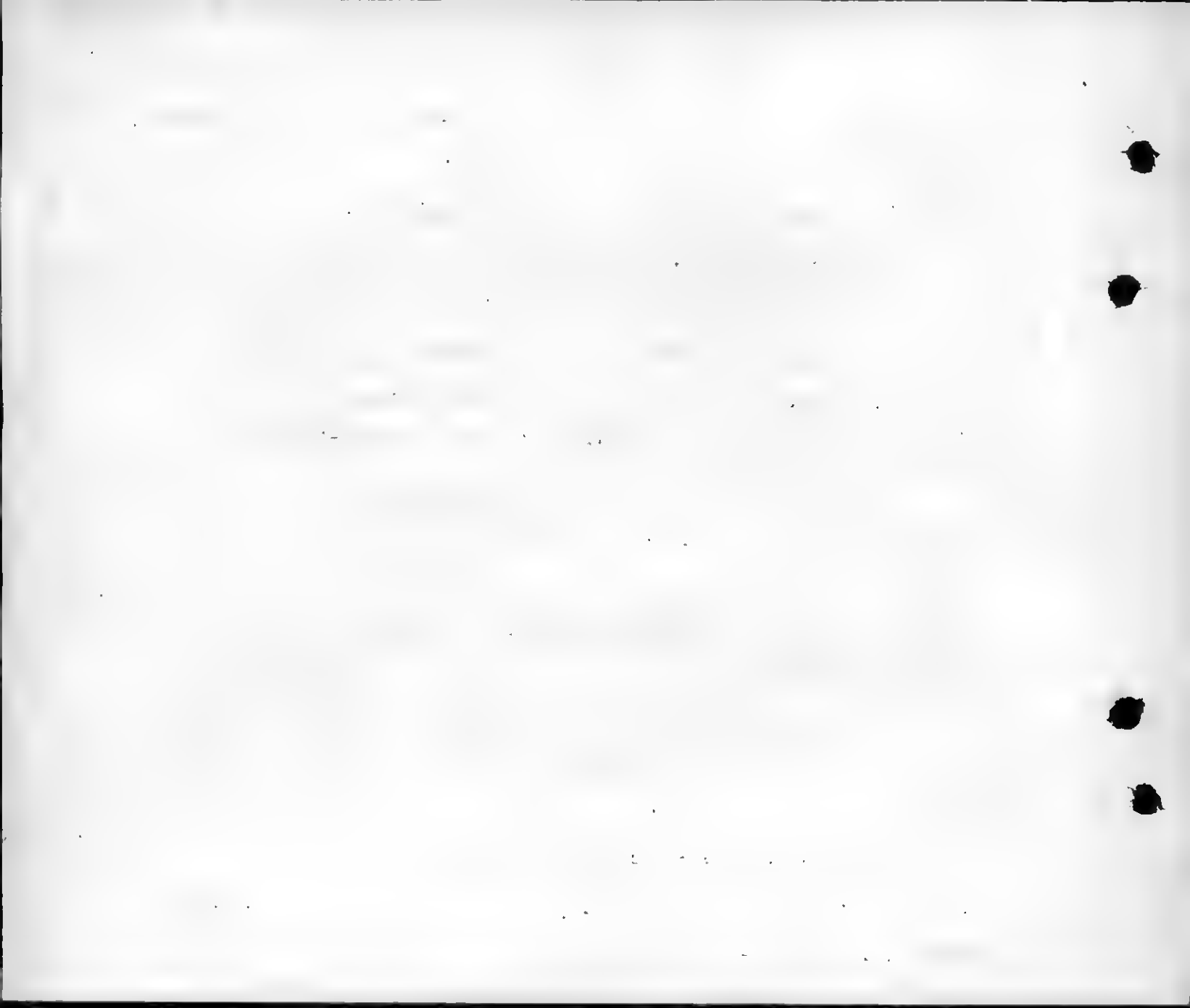
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> c. LENGTH OF STAY IN lb <b>Rockville</b> d. NAME OF HOSPITAL (If not in hospital give street address) <b>713 Mapleton Drive</b>		2. USUAL RESIDENCE (Where deceased lived If institut on: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b> d. STREET ADDRESS <b>713 Mapleton Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>GEORGE A. ELMORE</b>		4. DATE OF DEATH Month Day Year <b>June 13, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 1, 1885</b>
9. AGE (In years last birthday) <b>74</b>		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>12</b> Hours <b>12</b> Min <b>12</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>George M. Elmore</b>		14. MOTHER'S MAIDEN NAME <b>Mary Houser</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-30-3571</b>	
INFORMANT <b>Lillian E. Elmore-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cachexia &amp; anemia</b> 150.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>metastatic carcinoma</b> DUE TO (c) <b>carcinoma of liver</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary Emphysema</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>6 mos.</b> <b>1 yr</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1</b> , 19 <b>54</b> , to <b>6/13</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/13</b> , 19 <b>59</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>6/13/59</b>			
ACTUAL SIGNATURE <b>Stephen N. Jones</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Stephen N. Jones-Rockville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/15/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Union Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Leesburg, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6945

## CERTIFICATE OF DEATH

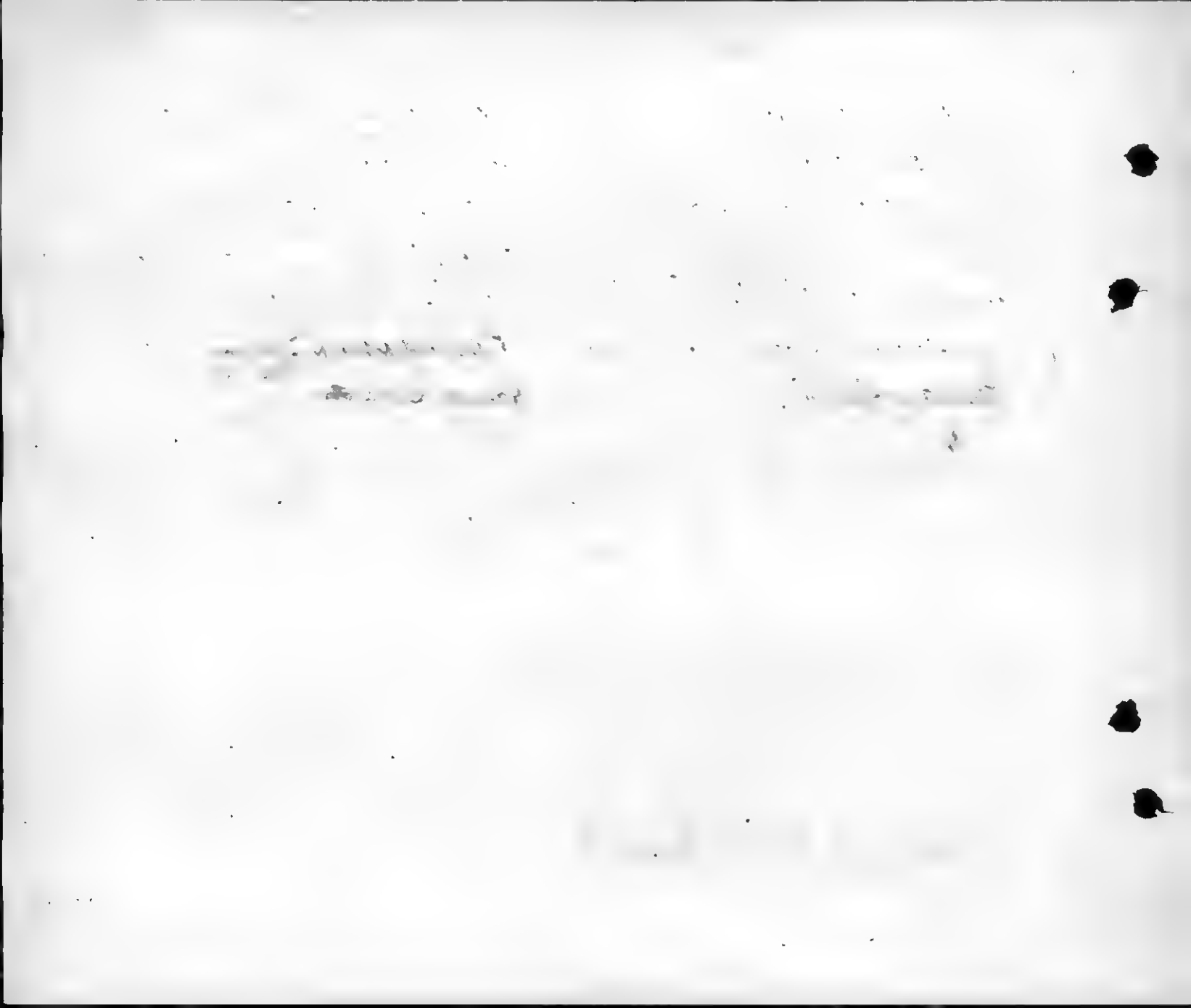
06915

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>4 hrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN HOSPITAL</u>		e. STREET ADDRESS <u>19708 BELLEVUE DRIVE</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET G. FITZPATRICK</u>		4. DATE OF DEATH Month Day Year <u>6 8 1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/13/88</u>
9. AGE (In years lost birthday) <u>70</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
11. BIRTHPLACE (State or foreign country) <u>Ballaghaden, Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Liblin</u>		14. MOTHER'S MAIDEN NAME <u>Honora Liblin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>454X Anti Thrombosis - abdominal</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Arteriosclerosis</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hospital Records - Bethesda Md.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/8</u> , 1959, to <u>6/8</u> , 1959, that I last saw the deceased alive on <u>6/8</u> , 1959, and that death occurred at <u>11:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas A. Hufnagel</u>		ADDRESS (Street, city or town, state) <u>3800 Rowland Rd. NW. Washington, D.C.</u>	
PHYSICIAN'S NAME (Type) <u>THAS. A. HUFNAGEL</u>		DATE SIGNED <u>6/8/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-11-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>—</u>		22d. LOCATION (City, town, or county) (State) <u>BUFFALO, NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Martin W. Hysong Co.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 10 '59</u>	
ADDRESS <u>1300 N. ST. NW. D.C.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the registrar.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. The certificate should be executed by the Medical Examiner's Office along with form PM-3. Page 5 of the certificate should be retained for your files. TO FUNERAL DIRECTOR: Page 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2 '57

FOR STATE  
HEALTH DEPT.

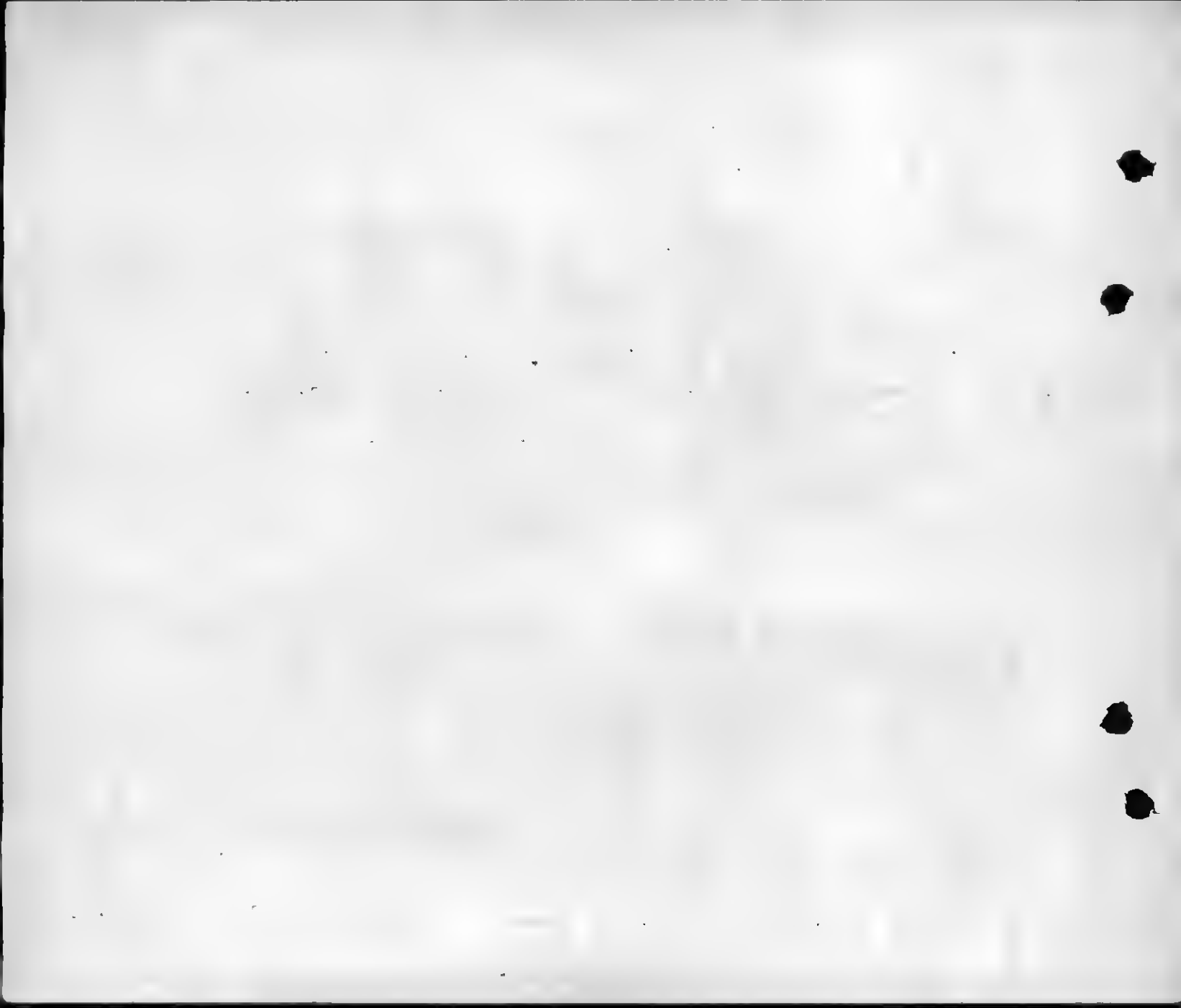
6897 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06916

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institut on. Residence before adm ssion) a. STATE <u>md</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Gaithersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>md 18-115</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elmer Sidney Fitzwater</u>		4. DATE OF DEATH <u>June 4 1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-85</u>
9. AGE (in years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <u>Carpenter Building Con.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>West Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Cyprianus Fitzwater</u>		14. MOTHER'S MAIDEN NAME <u>Clarenda Delawder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Cora Fitzwater</u>		Address <u>Same As 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4:20:1</u> DUE TO (b) <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hemorrhage into atherosclerotic plaque</u>		INTERVAL BETWEEN ONSET AND DEATH (a) <u>Hours</u> (b) <u>Hours</u> (c) <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Mucoid obstruction of trachea and aspiration gastric contents</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschant</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Spec. 1y) <u>Burial</u>		22b. DATE THEREOF <u>June 6</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Valley View</u>		22d. LOCATION (City, town, or county) (State) <u>Nokesville Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Coy W. Barber</u>		ADDRESS <u>Laytonsville, Md.</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	
DATE <u>JUN 8 '59</u>			

6-4-59





1  
FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the State Medical Examiner's Office along with form PMS. Pages 1, 2, and 3 should be retained for your files. TO FUNERAL DIRECTOR: Page 4 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 48 hours after death.

6946

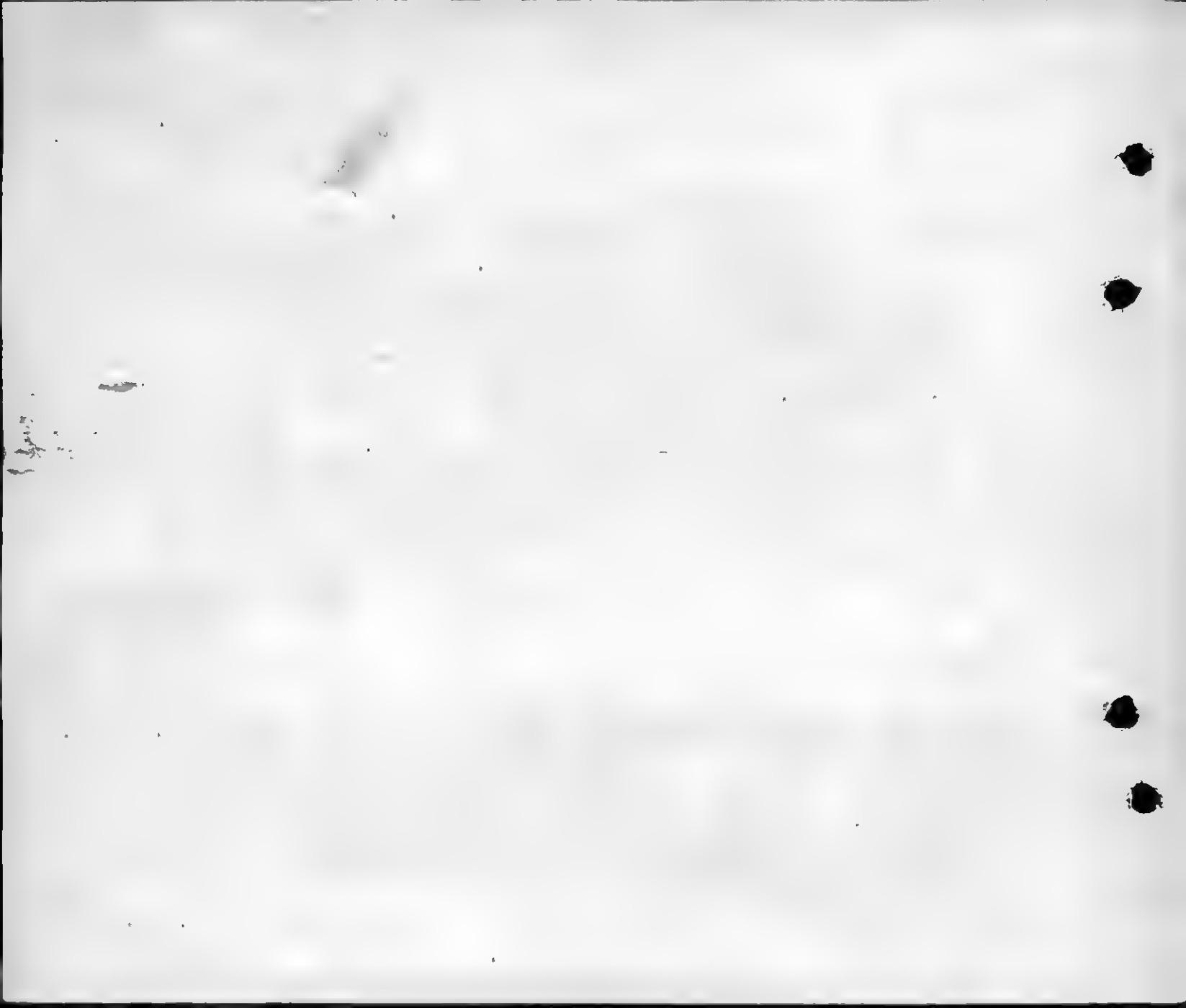
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 11 Filed 6/24/59 et

06917

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montg. Co. Gen. Hosp.</u>		d. STREET ADDRESS <u>Watkins Rd. R-1 Ex</u>	
3. NAME OF DECEASED (Type or print) <u>William T. Flynn Jr.</u>		4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/20/1909</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Howard Co., Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm. T. Flynn Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Ada Mullnix</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>217-28-2136</u>	
17. INFORMANT <u>Police Record.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>crushed neck and chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>crushed neck and chest</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Driver of farm tractor which upset</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>1:00 p.m. 6/29/59</u>		20d. INJURY OCCURRED White <input checked="" type="checkbox"/> Not white <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) (County) (State) <u>Woodfield Montg. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Spec. fy) <u>Burial</u>		22b. DATE THEREOF <u>7/3/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Howard Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Long Corner, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Oliver L. Mowbray</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hume</u>	
ADDRESS <u>Damascus, Md.</u>		DATE JUL 2 '59	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6947

## CERTIFICATE OF DEATH

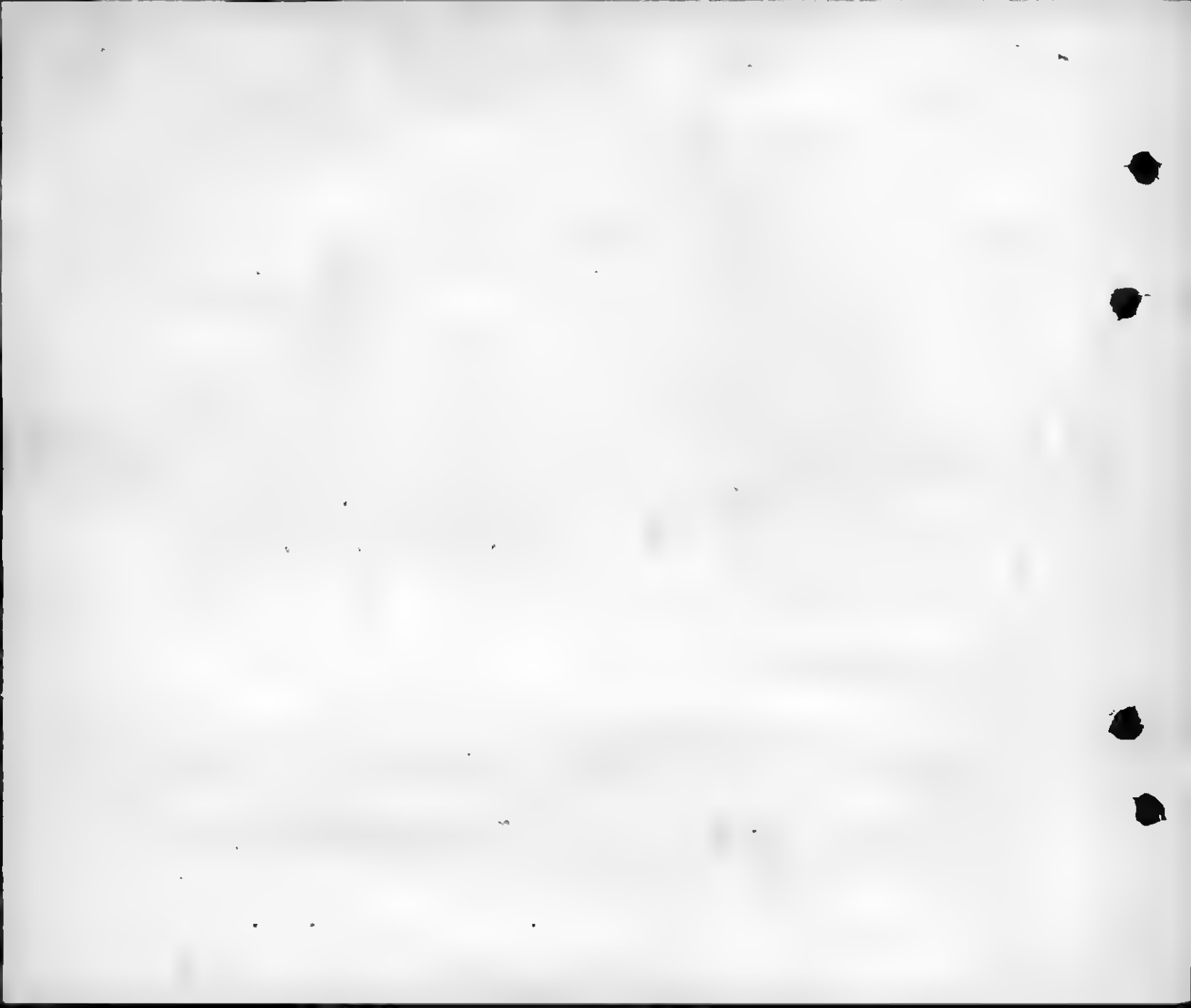
06918

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Asbury Methodist Home</u>		d. STREET ADDRESS <u>709 N. Milton Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Eleanor Ford</u>		4. DATE OF DEATH Month <u>6</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-12-1878</u>
9. AGE (In years last birthday) <u>80</u> yrs		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	11. IF UNDER 24 HRS Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Worker-Book Bindery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Worker-Bookbindery</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel C. Ford</u>		14. MOTHER'S MAIDEN NAME <u>Anne C. Redner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-07-3405</u>	
17. INFORMANT <u>Asbury Methodist Home for the Aged</u>		Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR ACCIDENT</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5-26-59</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>6-4</u> 19 <u>58</u> , to <u>6-9</u> 19 <u>59</u> , that I last saw the deceased alive on <u>6-8</u> 19 <u>59</u> , and that death occurred at <u>1:30P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sarah E. Glover</u>		ADDRESS (Street, city or town, state) <u>10128 CEDAR LAKE NEWINGTON, MD.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Sarah Elizabeth Glover</u>		DATE SIGNED <u>6-9-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/11/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto.</u>		24a. REC'D BY REGISTRAR <u>JUN 10 1959</u>	
ADDRESS <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur B. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

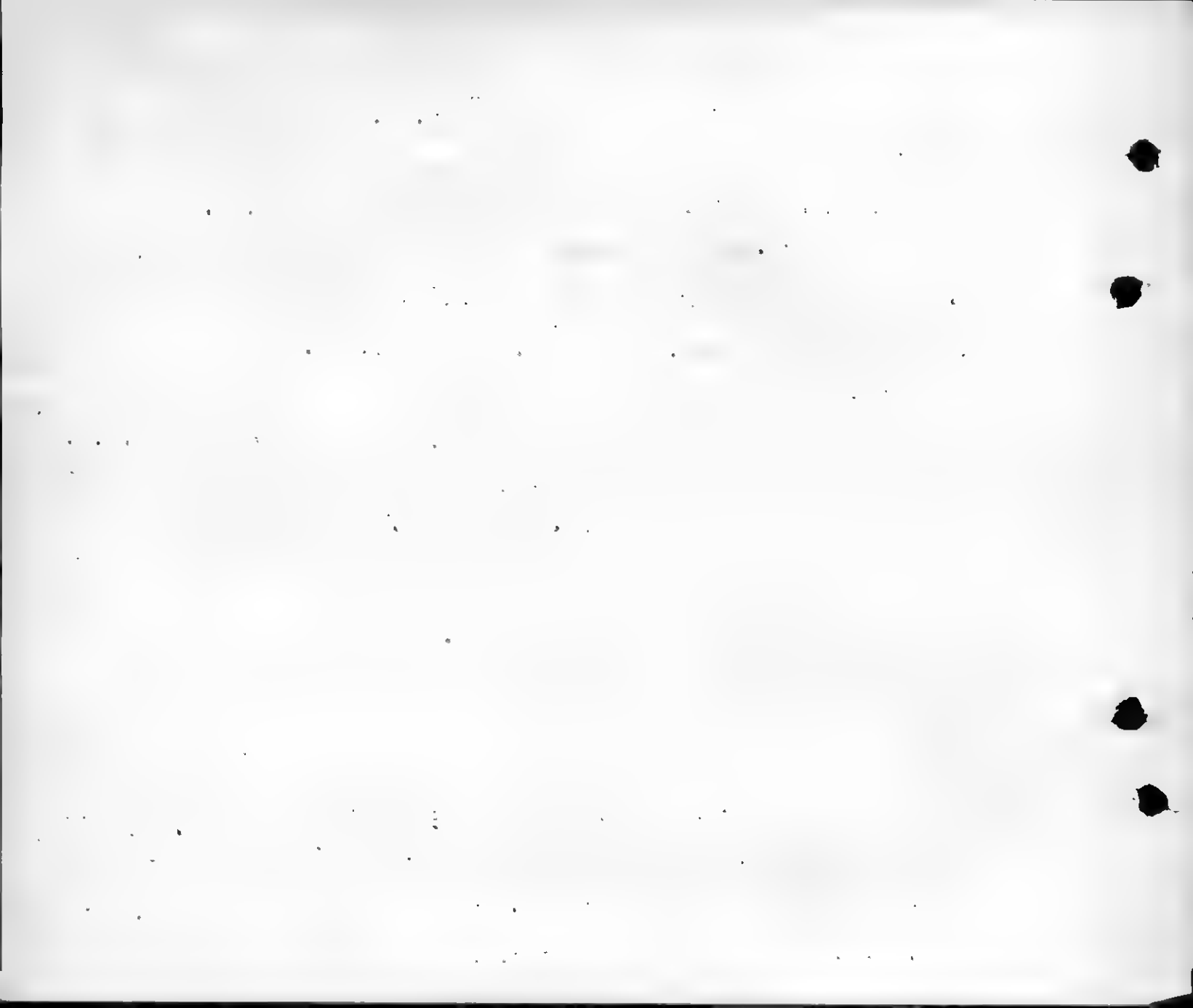
## CERTIFICATE OF DEATH

06919  
Reg. Dist. No.

6948

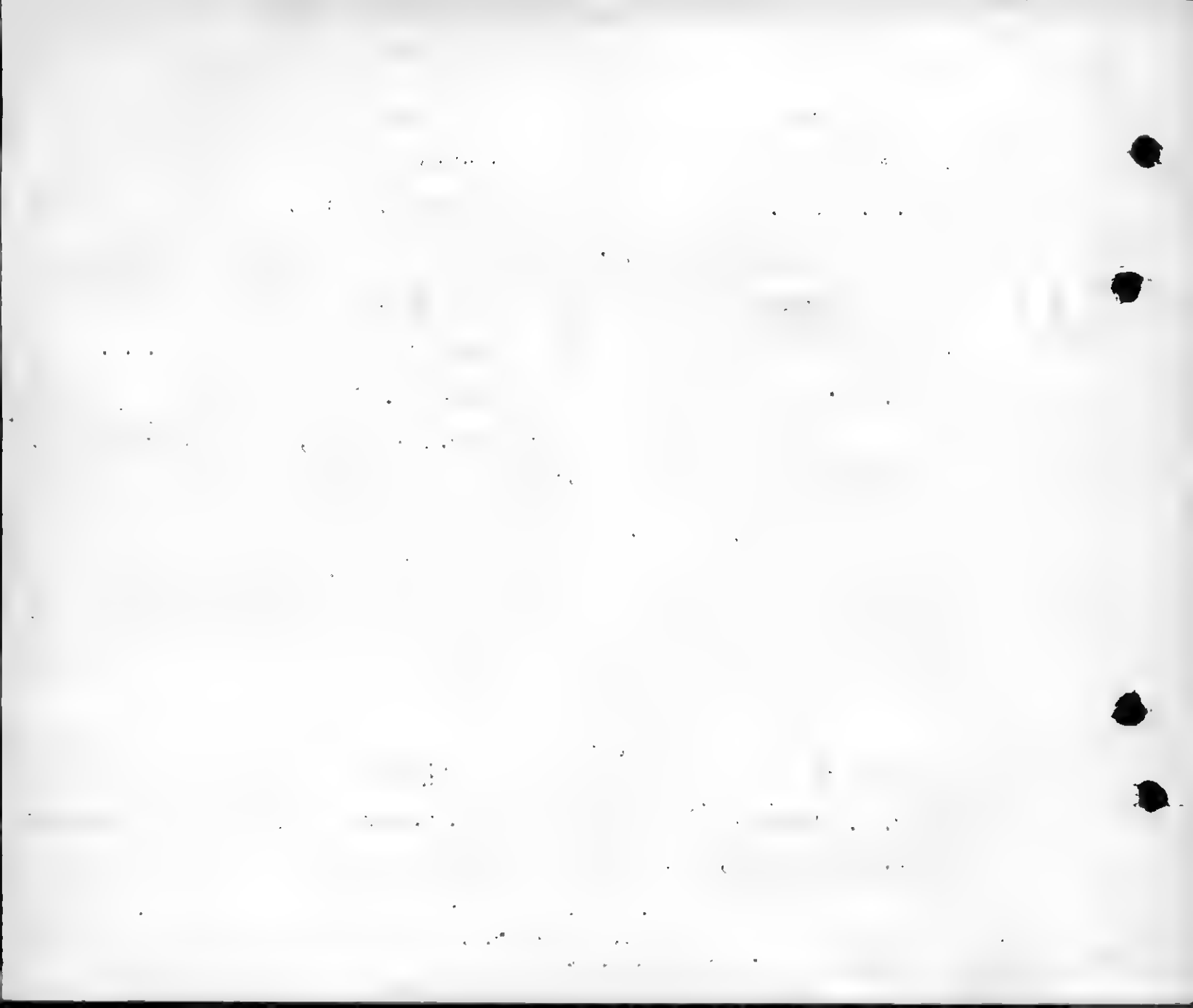
1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>47x</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6505 Callander Drive</b>		d. STREET ADDRESS <b>14 Bryant Street N. W.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>John</b> Last <b>Foster</b>		4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>1959</b>	
5 SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/19/1880</b>
9. AGE (In years last birthday) yrt. <b>79</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>29</b> Hours <b>10</b> Min.	11. IF UNDER 24 HRS Months <b>10</b> Days <b>29</b> Hours <b>10</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Baker-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Baking Co. Baltimore, Md.</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis Foster</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>unknown</b>	
17. INFORMANT <b>Wilbur A. Foster -14 Bryant St. N.W.</b>		Address <b>Washington, DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured Aneurysm of abdominal aorta</b> 4 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>10 yrs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-25</b> , 19 <b>34</b> to <b>6-29</b> , 19 <b>59</b> that I last saw the deceased alive on <b>6-26</b> , 19 <b>59</b> , and that death occurred at <b>10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4201 New Hampshire 6/24/59</b> DATE SIGNED ACTUAL SIGNATURE <b>Chas W Harnsberger</b> M.D. PHYSICIAN'S NAME (Type) <b>Chas. W. HARNSEBERGER</b> <b>Washington DC</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>7-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Company-Washington, D.C.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

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TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or funeral director. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Page 4  
TO HOSPITAL OR A FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or the attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06920	
Item 9 Filed 7-8-59 et											
6949											
CERTIFICATE OF DEATH										Reg. Dist. No. 215	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>					b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>					c. LENGTH OF STAY IN lb <b>15 days</b>	
2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>					b. COUNTY <b>Hyattsville</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					e. STREET ADDRESS <b>834 Berkshire Drive</b>					f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Nellie Commo FULLER</b>					4. DATE OF DEATH Month Day Year <b>29 June 19 59</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11 October 1895</b>		9. AGE (In years last birthday) yrs. <b>63 6/1</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>					10b. KIND OF BUSINESS OR INDUSTRY <b>Vermont</b>					11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>William H. COMMO</b>					14. MOTHER'S MAIDEN NAME <b>Ellen KINNEY</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO. <b>NONE</b>					INFORMANT <b>Stanley R. FULLER, YNC, USN RET Hyattsville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery</b> <b>1120.0</b> DUE TO <b>Antemortem Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized metastatic Carcinoma</b> lying cause last. (c) <b>6 wks?</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June 14</b> , 19 <b>59</b> , to <b>June 29</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 29</b> , 19 <b>59</b> , and that death occurred at <b>4:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>29 June 59</b> ACTUAL SIGNATURE <b>F. H. O'CONNELL</b> M.D. <b>F. H. O'CONNELL, LT MC USN</b> Bethesda, Maryland PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>7-2-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Memorial</b>			22d. LOCATION (City, town, or county) (State) <b>Hyattsville Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>			4th and Mass. Avenue, N.E., Washington, D. C.			24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			





TO HOSPITAL OR A Dying Physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filled with the registrars prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies.

VS A15 (4)  
15M 9/58

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

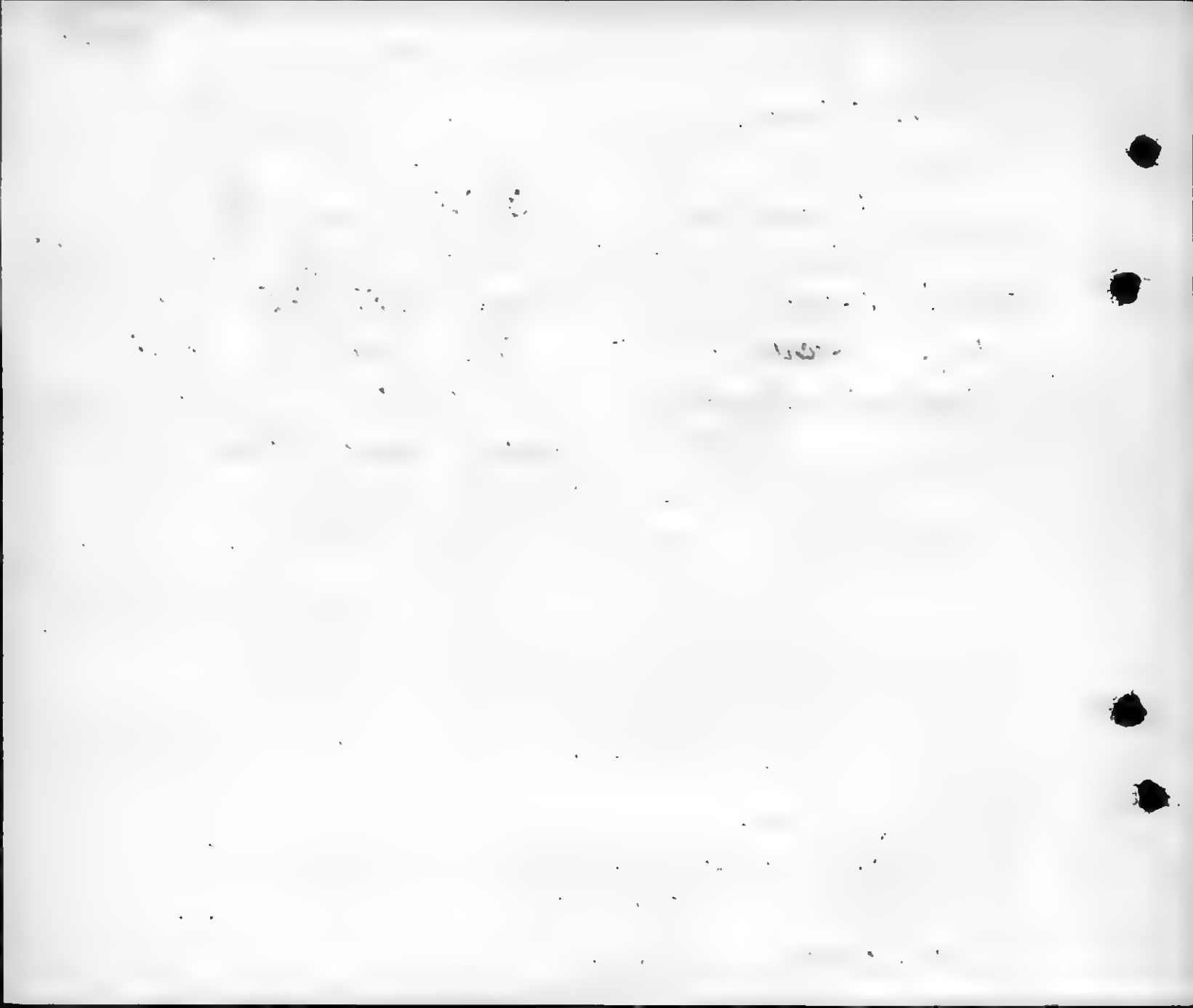
6950

## CERTIFICATE OF DEATH

06921

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>8 hours</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>				d. STREET ADDRESS <u>3119 Fernside St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Motillo</u> Middle <u>Smith</u> Last <u>Garsch</u>				4. DATE OF DEATH June 4, 1959			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 27, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales at Dept. Store</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Barnet Smith</u>				14. MOTHER'S MAIDEN NAME <u>unknown (Warsaw)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO <u>Yes</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Nervous System</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Hemiplegia</u> DUE TO (c) <u>Myocardial Infarction</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 Hr.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>None</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>5:15</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5/1/59</u> , 19 <u>58</u> , to <u>6/4/59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/4/59</u> , 19 <u>59</u> , and that death occurred at <u>Home</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sam Allen</u>				ADDRESS (Street, city or town, state) <u>6/4/59</u> DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Sam Allen, Kensington, Maryland</u>				M.D. <u>Kensington, Maryland</u>			
22a. BURIAL, CREMATON, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>6/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>George Washington Medical School</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey-Bethesda, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	



6951

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) o STATE b. COUNTY <u>Washington, D.C.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Greenhouse Nursing Home</u>		d. STREET ADDRESS <u>5400 57th St NW</u>	
3. NAME OF DECEASED (Type or print) First <u>Blanch</u> Middle <u>Teresa</u> Last <u>Seigen</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14, 1885</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Kemp</u>		14. MOTHER'S MAIDEN NAME <u>Catherine</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unknown) <u>No</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Gertrude Shelburn</u>		Address <u>613 Delaware St Wash D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A.S.H.D. &amp; Hypertension</u> (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>Many years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>MAY 1959</u> to <u>6-30</u> , 1959, that I last saw the deceased alive on <u>6-30</u> , 1959, and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Beveridge Miller</u> M.D.		ADDRESS (Street, city or town, state) <u>1028 Conn Ave NW</u>	
PHYSICIAN'S NAME (Type) <u>BEVERIDGE MILLER</u>		DATE SIGNED <u>July 1, 1959</u>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-3-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Wash, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Mattingly</u>		ADDRESS <u>131-11 44th St Wash D.C.</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6952

## CERTIFICATE OF DEATH

Reg. Dist. No.

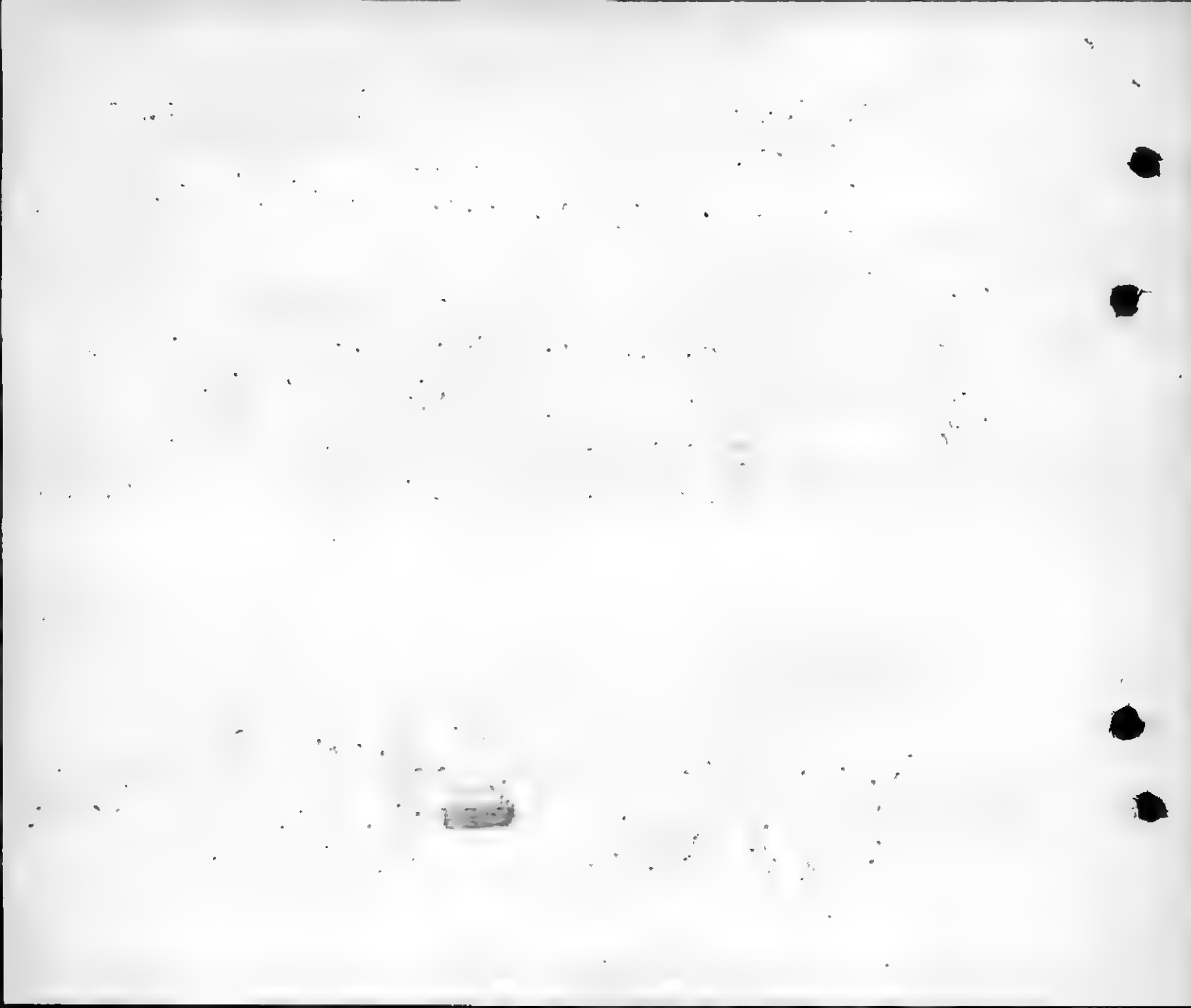
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garrett Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>T.</u> Last <u>German</u>		4. DATE OF DEATH Month <u>6</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	COLOR OR RACE <u>W.</u>	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-81</u>
9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u>7</u> Days <u>27</u> Hours <u>19</u> Min <u>59</u>	IF UNDER 24 HRS Months <u>7</u> Days <u>27</u> Hours <u>19</u> Min <u>59</u>	10. BIRTHPLACE (State or foreign country) <u>U. S. A</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Suburban Hosp</u>	
13. FATHER'S NAME <u>John A. German</u>		14. MOTHER'S MAIDEN NAME <u>Roberta C. Allison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Name, no. or unknown) <u>No.</u>		16. SOCIAL SECURITY NO <u>577-46-9516</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Neurological meningitis</u> DUE TO (b) <u>48 hrs</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		18. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 27, 1959</u> to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 27, 1959</u> , and that death occurred at <u>1045</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>George A. Garret</u>		DATE SIGNED <u>6/27/59</u>	
PHYSICIAN'S NAME (Type) <u>George A. Garret</u>		ADDRESS (Street, city or town, state) <u>Cherry Chase Drive 15 MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>	22b. DATE THEREOF <u>6/30/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Abbey Mausoleum</u>	22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Jul 2 '59</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE <u>Julius L. Thomas</u>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or funeral director. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director. After the certificate has been signed by the attending physician and completed, it should be filed with the funeral director.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



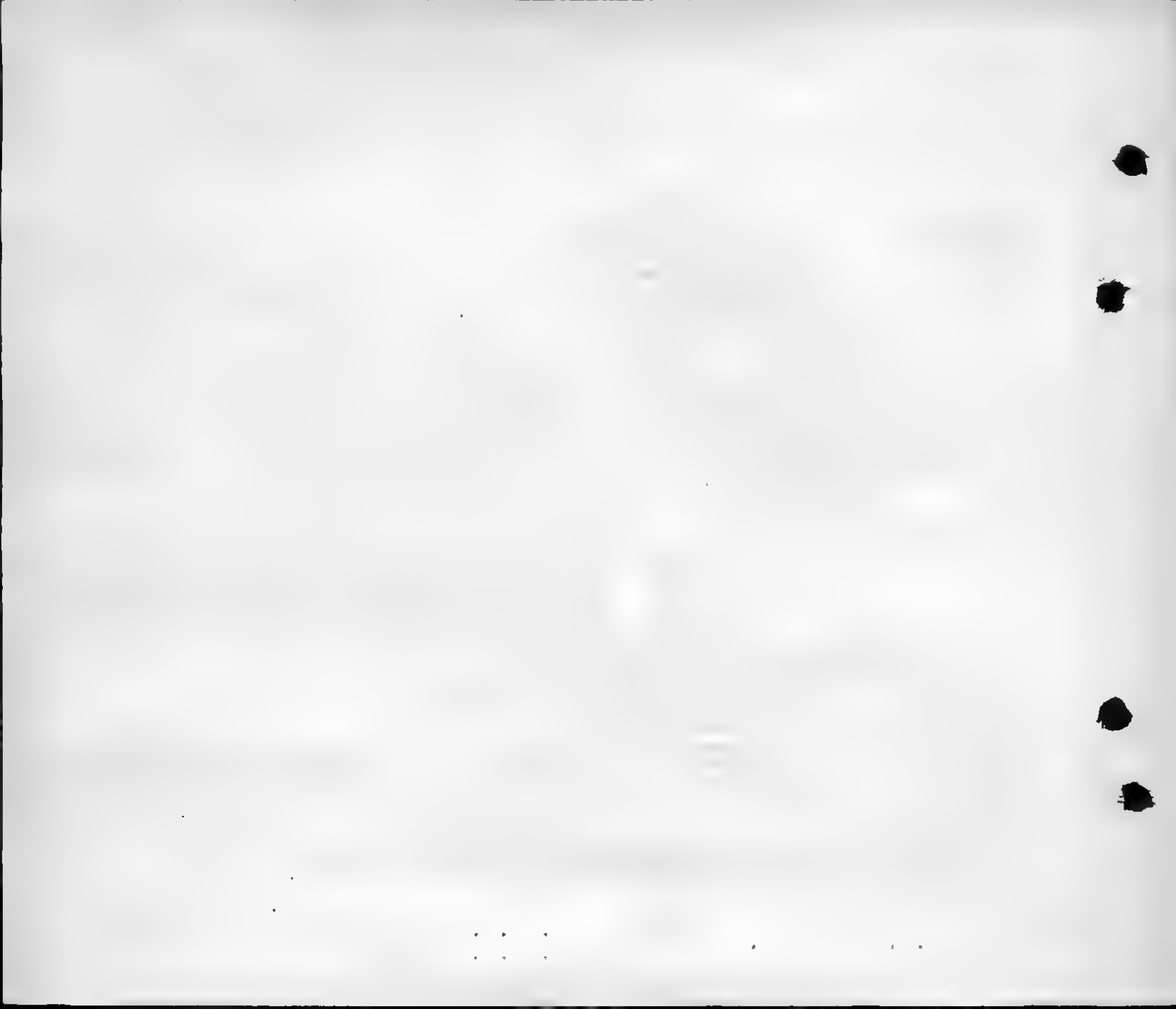
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> <u>1615 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Sanitarium &amp; Hosp.</u>		d. STREET ADDRESS <u>1417 Ruatan St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Winifred Adele Gibbons</u>		4. DATE OF DEATH Month Day Year <u>June 11 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, 1925</u>
9. AGE (In years last birthday) <u>33</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NA.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Vogt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Stombeck</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Husband - 1417 Ruatan St. Hyattsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exsanguination</u> <u>612X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ruptured Lower Uterine Muscle.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Term Pregnancy - Delivery</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9 June 1959</u> to <u>11 June 1959</u> , that I last saw the deceased alive on <u>11 June 1959</u> , and that death occurred at <u>10:53 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.		ADDRESS (Street, city or town, state) <u>8801 Colesville Rd. 6/11/59</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold Silver Spring, Md.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Luray, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co.</u>		24a. REC'D BY REGISTRAR <u>2901 14th St. N.W. Washington 9, D.C.</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06925

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X CHEVY CHASE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Hudson Soc.</u>		d. STREET ADDRESS <u>4008 THORNAPPLE STREET</u>	
3. NAME OF DECEASED (Type or print) <u>SMORIN</u> First Middle Last <u>St. Hill</u>		4. DATE OF DEATH <u>6</u> Month <u>23</u> Day <u>1959</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 25, 1870</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEON GUINSBURG</u>		14. MOTHER'S MAIDEN NAME <u>BESSIE SCHLOSBERG</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1898-1899</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>EPHRAIM JACOBS</u>		Address <u>4008 THORNAPPLE ST., CH.CH., MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>420.0</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Senility - age (7)</u> (c) <u>87yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u> <u>yr</u> <u>yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 2</u> , 19 <u>58</u> , to <u>6/23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>59</u> , and that death occurred at <u>12:00</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sam Allen</u>		ADDRESS (Street, city or town, state) <u>Kensington, Md</u> DATE SIGNED <u>6/23/59</u>	
PHYSICIAN'S NAME (Type) <u>ALLEN</u>		<u>KENSINGTON, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Type) <u>BURIAL</u>		22b. DATE THEREOF <u>6/25/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NAT'L CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>FORT MYER, VIRGINIA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Hawler's Sons</u> ADDRESS <u>1756 Pa. Ave., N.W.</u>		24a. REC'D BY REGISTRAR <u>JUN 24 '59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Haus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

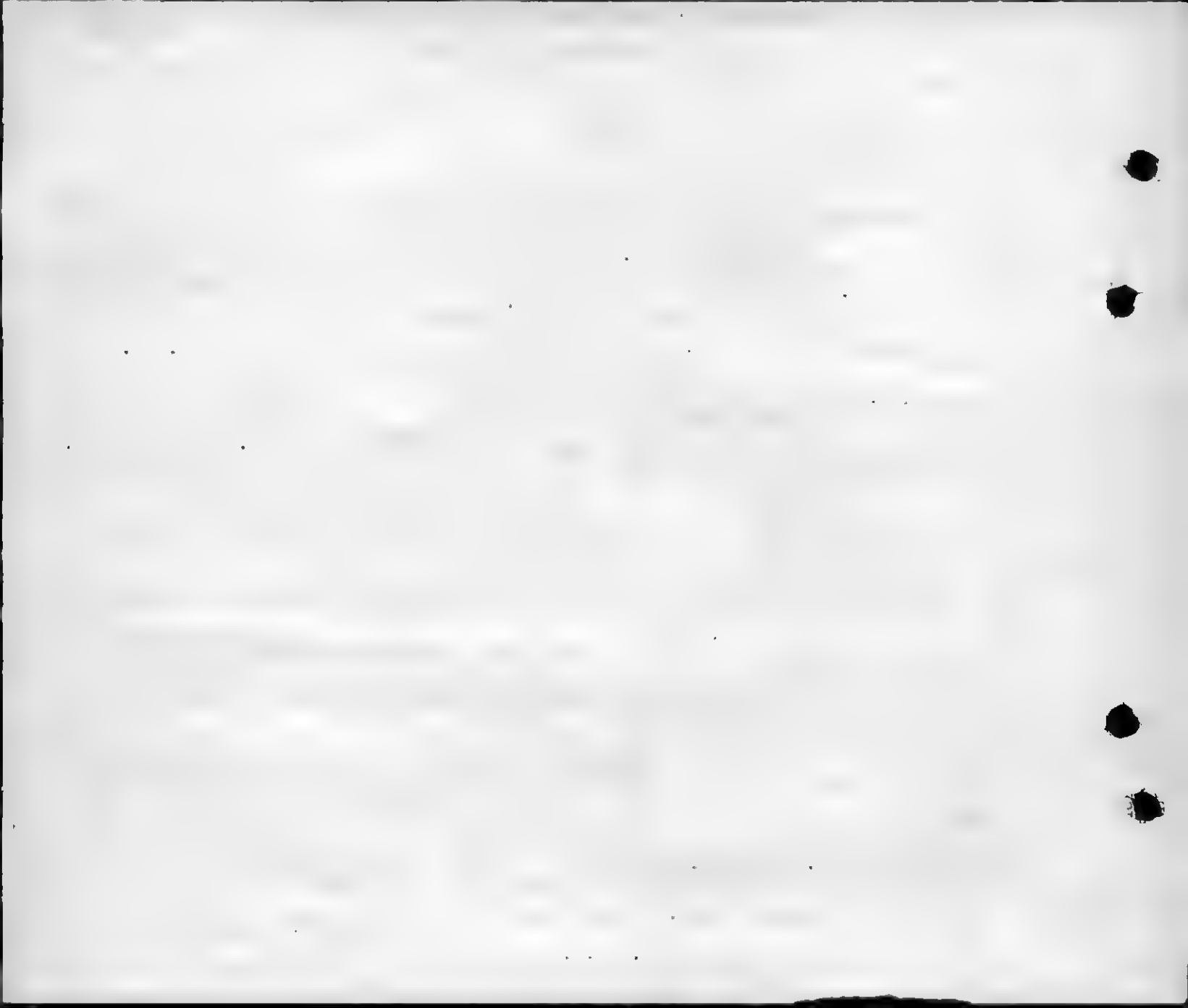
06926

6880

## CERTIFICATE OF DEATH

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>			<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1111 HOLTON LANE</u>			d. STREET ADDRESS <u>1111 HOLTON LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>HARRY</u> <u>L.</u> <u>GOLD</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>JUNE</u> <u>17</u> <u>1959</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. COLOR OR RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <u>DEC. 1883</u>		<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS:
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>MERCHANT-RETIRED</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (State or foreign country) <u>POLAND</u>	
<b>13. FATHER'S NAME</b> <u>MORRIS N. GOLD</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>		
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> 		<b>17. INFORMANT</b> Address <u>DAVID GOLD 8603 BARRON ST., WASH., 12, D.C.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary heart failure and uremia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease + generalized arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>10 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Hour o. m. p. m.	Month, Day, Year 19	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b>	(County) (State)
<b>21. I certify that I attended the deceased from</b> <u>July 9</u> , 19 <u>57</u> , to <u>June 17</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 17</u> , 19 <u>59</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Blair H. Eig</u> M.D. <u>2641 Coleville Rd. Silver Spring, Md. June 17, 1959</u> PHYSICIAN'S NAME (Type) <u>BLAIR H. EIG, M.D.</u>					
<b>22a. BURIAL, CREMATION, or other disposal</b> (Specify) <u>BURIAL</u>	<b>22b. DATE THEREOF</b> <u>6-19-59</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MT. LEBANON CEMETERY</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>HYATTSVILLE, MARYLAND</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>B. DANZANSKY &amp; SONS 3501 14th ST., N.W.</u>			<b>24a. REC'D BY REGISTRAR</b> <u>JUN 29 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Colin L. Kline</u>



## 6954 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN IT <b>20 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1132 New Jersey Avenue, S. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Prentiss</b>		First <b>(none)</b>		Middle <b>Goodwin</b>		Last <b>Goodwin</b>		4. DATE OF DEATH Month <b>June</b> Day <b>4,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 25, 1936</b>		9. AGE (In years last birthday) <b>23</b> yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Excavating</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Oran Goodwin</b>				14. MOTHER'S MAIDEN NAME <b>Amey Davis</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>248-50-9265</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>133X</b> DUE TO <b>Hermination and displacement of cerebellum - days</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebellar abscess - occidodromycosis 6 mos</b> (c) <b>Pulmonary Occidodromycosis 4 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15,</b> 19 <b>59</b> , to <b>June 4,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>June 4,</b> 19 <b>59</b> , and that death occurred at <b>11:50A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 6/4/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>									
ACTUAL SIGNATURE <b>Albert Tregger</b> M.D.				PHYSICIAN'S NAME (Type) <b>ALBERT TREGER, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>6-6-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hamlet, N.C.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Barnes &amp; Matthews</b>				ADDRESS <b>3619-14th St. NW</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove your portion of the certificate.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6955 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

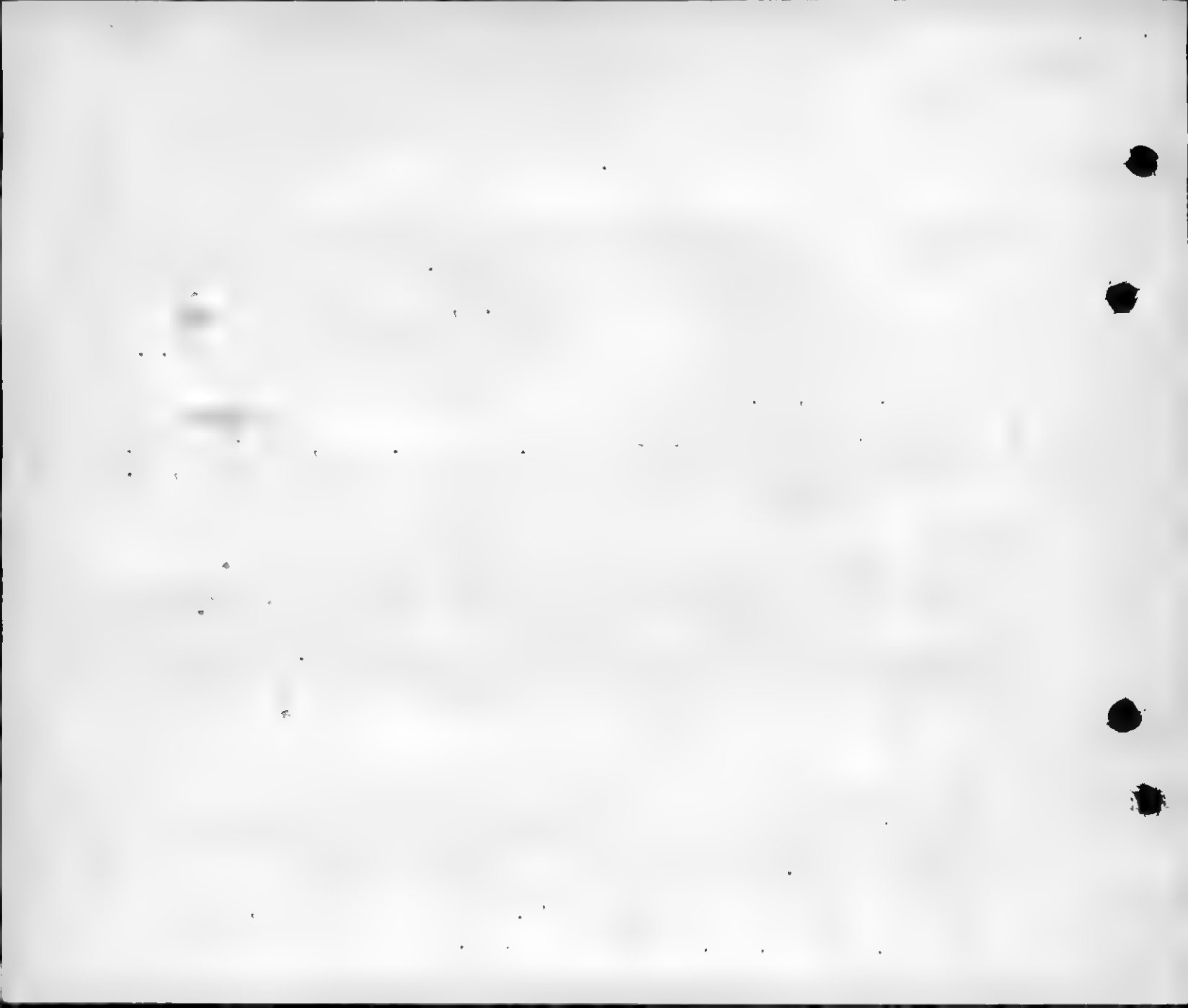
06927

FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <span style="float: right;">b. CITY OR TOWN <b>SILVER SPRING</b></span>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> <span style="float: right;">b. COUNTY <b>MONTGOMERY</b></span>			
c. LENGTH OF STAY IN 1b <b>8 yrs.</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3505 FLORAL STREET</b>				d. STREET ADDRESS <b>3505 FLORAL STREET</b>			
3. NAME OF DECEASED (Type or print) <b>JOSEPH VINCENT GOUGH JR.</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>30</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUG. 4, 1916</b>	
9. AGE (in years last b. rthday) <b>42 yrs</b>		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Upholsterer (Mayflower Hotel)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>PENNSYLVANIA</b>			
13. FATHER'S NAME <b>JOSEPH V. GOUGH, SR.</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE DOUGHERTY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW #2 187-07-1883</b>		17. INFORMANT <b>Mrs. Blanche T. Gough, 3505 Floral St. Silver Spring, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Frank J. Broschart</i> EXAMINER'S NAME (Type) <b>FRANK J. BROSCART</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED <b>6/30/59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>7/3/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NAT'L. CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON, VIRGINIA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <i>Raymond E. Ziska</i>				24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6956

Item 2 11111111 7 4 10 11

## CERTIFICATE OF DEATH

06929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Chronic Hospital</u>				d. STREET ADDRESS <u>Route 3</u>			
3. NAME OF DECEASED (Type or print) First <u>Eleanor</u> Middle <u>House</u> Last <u>Gregg</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 8 - 1925</u>	
9. AGE (In years last birthday) <u>34</u> yrs		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even, if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>			
11. BIRTHPLACE (State or foreign country) <u>Gaithersburg, Md</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Benjamin Coleman</u>				14. MOTHER'S MAIDEN NAME <u>Carry E. Ricketts</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>  </u>				16. SOCIAL SECURITY NO. <u>  </u>			
17. INFORMANT <u>James M. Gregg</u>				Address <u>Rt. 3 Mt. Airy, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rt. Breast</u> <u>110X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ben. metastases</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 MO.</u> <u>3 MO</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>  </u> <u>  </u> <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <u>  </u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u> (County) <u>  </u> (State) <u>  </u>							
21. I certify that I attended the deceased from <u>18 March</u> , 1956, to <u>29 June</u> , 1959, that I last saw the deceased alive on <u>29 June</u> , 1959, and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Olney, Md</u> DATE SIGNED <u>29 June 59</u>							
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.				PHYSICIAN'S NAME (Type) <u>John B. Ziegler M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>July 1</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Tabor</u>		22d. LOCATION (City, town, or county) <u>Etchison</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gary W. Barber</u> ADDRESS <u>Laytonville, Md</u>				24a. REC'D BY REGISTRAR <u>  </u> DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

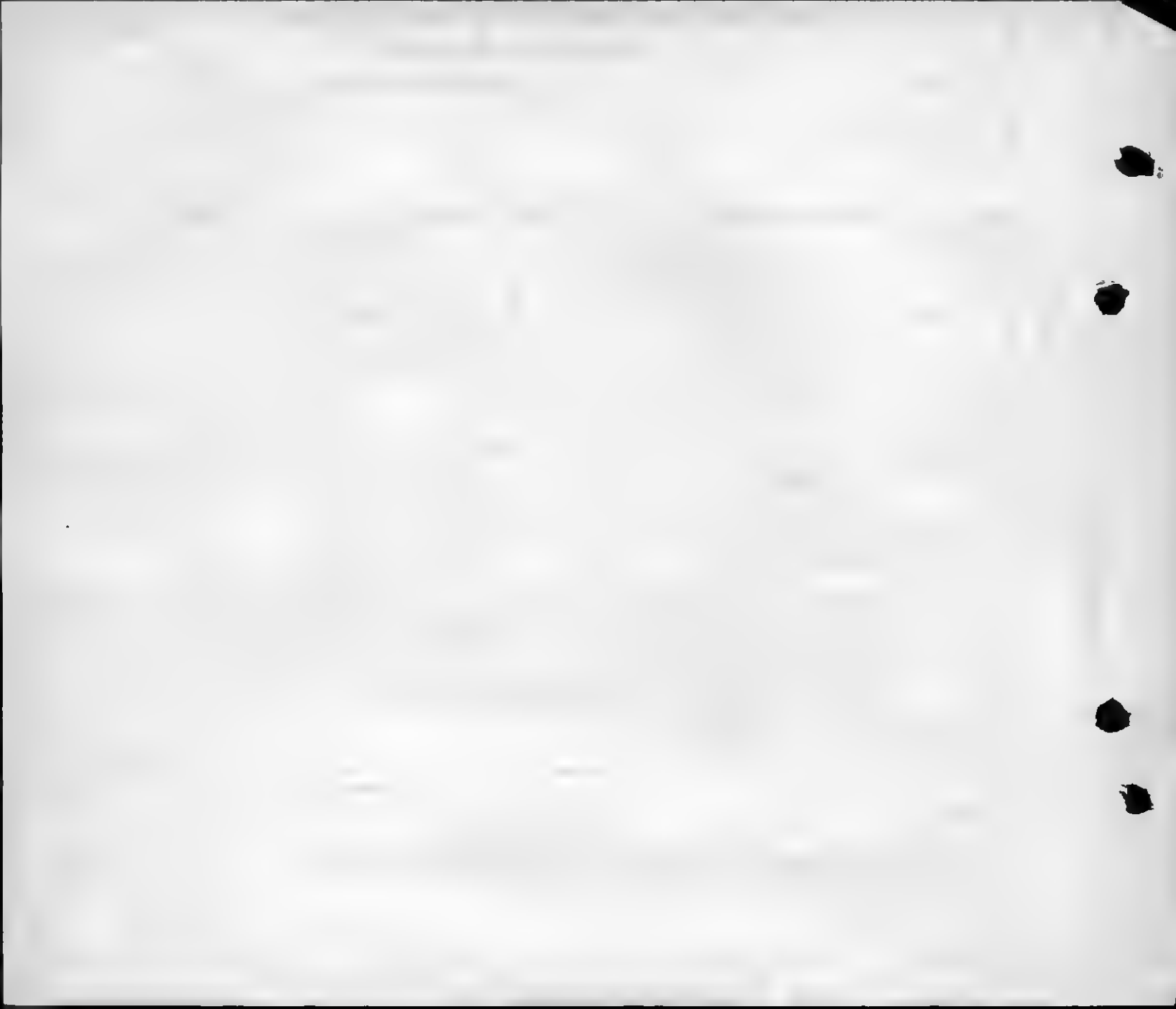


## 6881 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Iakoma Park</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
f. STREET ADDRESS <u>8712 Colesville Rd</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Irene</u> Middle <u>Maude</u> Last <u>Grove</u>				4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-12-82</u>	9. AGE (In years last birthday) <u>77</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>16</u> Hours <u>16</u> Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Charles Timmons</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Embrey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Leukemia</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Papillary adenocarcinoma bladder</u> (c) <u>Generalized metastases from Carcinoma Breast</u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>5 years</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pathological fracture Rt thigh due to bony metastases</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>1959</u> Hour a. m. <u>19</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1-10-1959</u> to <u>6-15-1959</u> , that I last saw the deceased alive on <u>6-16-1959</u> , and that death occurred at <u>6:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8005 Woodbury Drive</u> DATE SIGNED <u>McShawmabukid</u>							
ACTUAL SIGNATURE <u>McShawmabukid</u> M.D.				PHYSICIAN'S NAME (Type) <u>H. G. Shoemaker, M.D.</u> <u>Silver Spring, Maryland</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-18-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>FT LINCOLN</u>		22d. LOCATION (City, town, or county) (State) <u>BLADENSBURG MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Neal Funeral Home</u>				ADDRESS <u>4812 Ga Anom</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kram</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>10401 Montrose Avenue</b>		e. STREET ADDRESS <b>10401 Montrose Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>JAMES</b> Last <b>HAMILTON</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>16</b>	11. IF UNDER 24 HRS. Hours <b>10</b> Min. <b>16</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Collection Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>R.L Voight &amp; Co</b>	
11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>William Hamilton</b>		14. MOTHER'S MAIDEN NAME <b>? Longley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>364-14-1887</b>	
17. INFORMANT <b>Lela J Hamilton-daughter-same as 2d</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>151X Anemia, terminal</b> DUE TO <b>carcinomatosis, widespread</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma, stomach</b> DUE TO (c) <b>1 year</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>BRONCHITIS, CHRONIC</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>OCT. 19 57</b> to <b>6/19 19 59</b> , that I last saw the deceased alive on <b>6/19 19 59</b> , and that death occurred at <b>0850M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4892 BATTERY LAKE</b> DATE SIGNED <b>6/19/59</b>			
ACTUAL SIGNATURE <b>Charles J. Sumner, M.D.</b>		PHYSICIAN'S NAME (Type) <b>Charles J. Sumner, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/22/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Evans</b>		DATE <b>JUN 22 '59</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

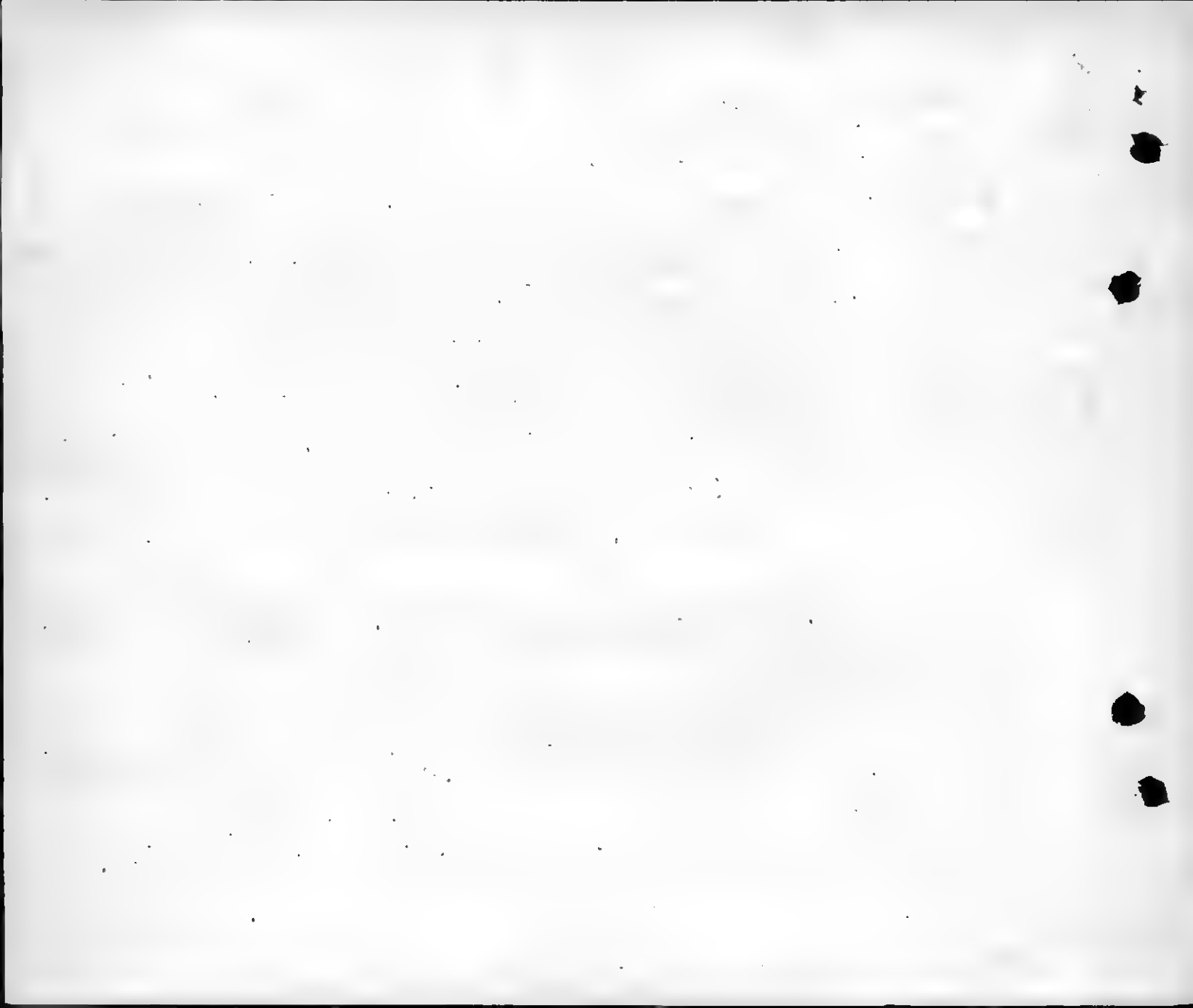
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) o. STATE <b>KENTUCKY</b> b. COUNTY <b>PULASKI</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SOMERSET</b>	
c. LENGTH OF STAY IN 1b <b>21 MONTHS</b>		d. STREET ADDRESS <b>110 COLLEGE STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>8604 Bradmoor Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MAMIE (No middle name) HARGIS</b>		4. DATE OF DEATH Month Day Year <b>JUNE 29, 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 28, 1892</b>
9. AGE (In years lost birthday) <b>67</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>KENTUCKY</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN R. HARRIS</b>		14. MOTHER'S MAIDEN NAME <b>NANCY JANE BULL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT Address <b>MRS. MARY L. SHORT 8604 BRADMOOR DR.</b>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO <b>CEREBRAL ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 DAYS</b> <b>20 YEARS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>MULTIPLE SCLEROSIS - 10 YEARS DURATION</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>OCTOBER 1957</b> to <b>JUNE 29, 1959</b> that I last saw the deceased alive on <b>JUNE 29, 1959</b> and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph D. Connor, M.D.</b>		ADDRESS (Street, city or town, state) <b>9420 Old Georgetown Road Bethesda 14, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>JOSEPH D. CONNOR, MD</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Bur. Trans.</b>	22b. DATE THEREOF <b>6/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Babbit Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Mark, Kentucky</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>	

TO HOSPITAL OR A BOARDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, the funeral director should be notified. The funeral director should be notified. The funeral director should be notified.

VS A15 (4)  
15M 9/58





6959

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>20hrs 16min</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Volusia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deland</b> d. STREET ADDRESS <b>Greens Lane, Blue Lake</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Deborah Kay HART</b>		4. DATE OF DEATH Month Day Year <b>June 22 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-59</b>
9. AGE (In years last birthday) yrs. <b>20</b>		10. IF UNDER 1 YEAR Months Days Hours Mins. <b>20 16</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>Bethesda, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Franklin HART</b>		14. MOTHER'S MAIDEN NAME <b>Donna Jean ROBINSON</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT <b>(f) Wm. F. Hart, same as #2</b>		Address	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Anoxia</b> <b>762.5</b> DUE TO (b) <b>Apnea + Central Nervous System Damage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Prematurity</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>2 hours</b> <b>2 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m., p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 21</b> , 19 <b>59</b> , to <b>June 22</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 22</b> , 19 <b>59</b> , and that death occurred at <b>6:35AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital 6-22-59</b>			
ACTUAL SIGNATURE <b>John H. Mazur</b>		M.D. <b>U. S. Naval Hospital</b>	
PHYSICIAN'S NAME (Type) <b>John H. MAZUR, LT, MC, USN</b>		<b>Bethesda 14, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment</b>	22b. DATE THEREOF <b>6-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bethany Baptist Church</b>	22d. LOCATION (City, town, or county) (State) <b>Gulf N. Carolina</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumpfrey</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>
R. A. Pumpfrey Funeral Home, Bethesda, Md.			

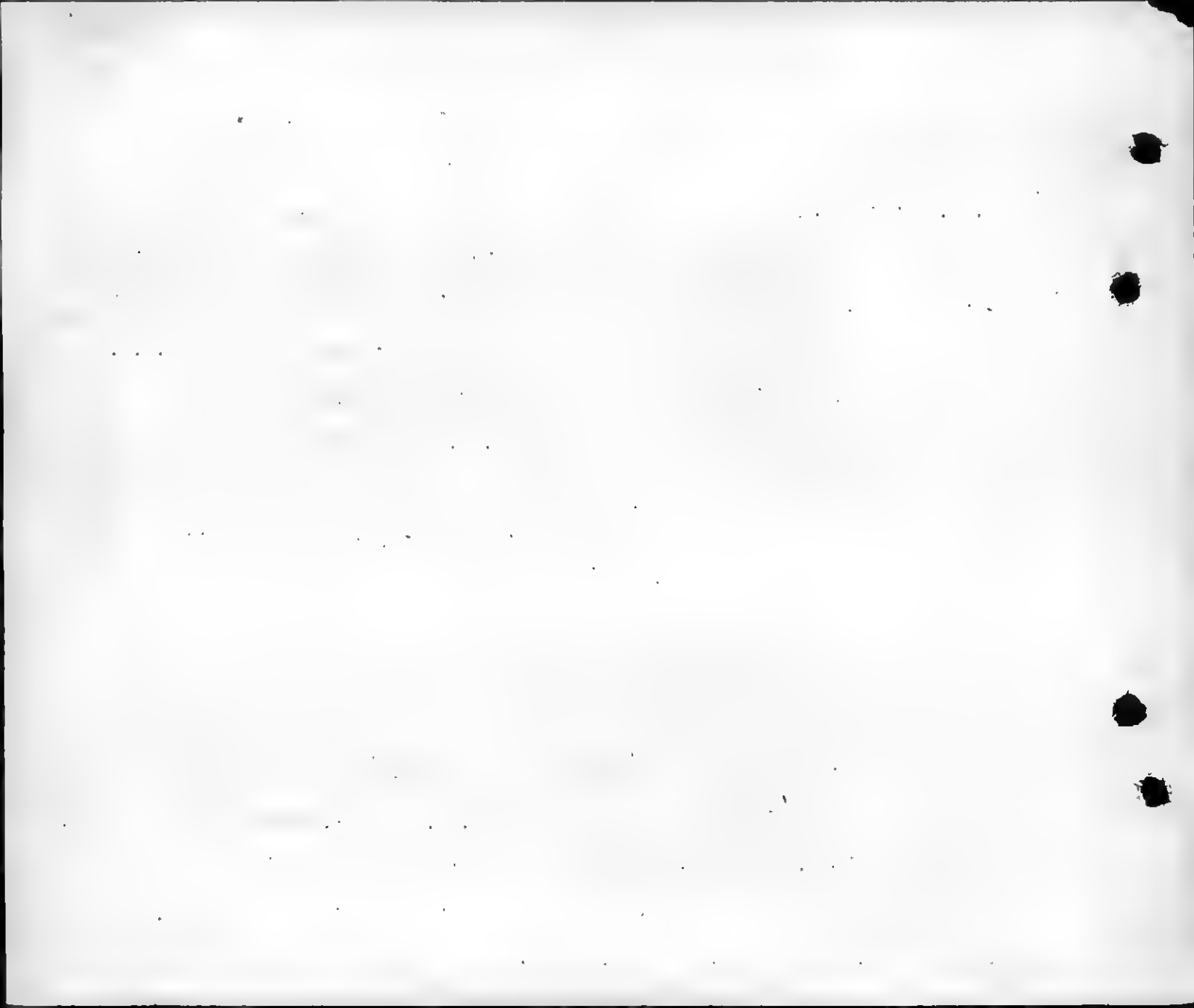
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Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.



6960

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Bethesda</u> <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>35 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. STREET ADDRESS <u>2720 Kirkwood Place</u>			
3. NAME OF DECEASED (Type or print) First <u>Bruce</u> Middle <u>Tipton</u> Last <u>Heffley</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1955</u>	
9. AGE (In years last birthday) <u>4</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Robert J. Heffley</u>				14. MOTHER'S MAIDEN NAME <u>Mary S. Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subdural Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Lymphocytic Leukemia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastrointestinal Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH Hours Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April 27, 1959</u> to <u>June 1, 1959</u> , that I last saw the deceased alive on <u>June 1, 1959</u> , and that death occurred at <u>7:00 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>HK Silberman</u> M.D.				DATE SIGNED <u>6-2-59</u>			
PHYSICIAN'S NAME (Type) <u>Harold R. Silberman, M. D.</u>				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The S.H. Hines Co., 2901 14th St. N.W.,</u>				ADDRESS <u>Wash, D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6961

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>40 hrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>2932 McKinnley St. N.W.</b>			
3. NAME OF DECEASED (Type or print) First <b>Edna</b> Middle <b>C</b> Last <b>Henshaw</b>				4. DATE OF DEATH Month <b>June</b> Day <b>16</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 13 1898</b>	9. AGE (In years lost birthday) <b>60 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Statistician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Serv. Com.</b>		11. BIRTHPLACE (State or foreign country) <b>Green Bowling, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wm. Ritter Carter</b>				14. MOTHER'S MAIDEN NAME <b>Imogene Hearn</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>no</b>		INFORMANT <b>Edmund L. Henshaw, Jr.</b> Address <b>Route 4-1111 Westbriar Ct Vienna, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Status Asthmaticus</b> DUE TO (b) <b>Bronchial Asthma</b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 5, 1959</b> to <b>June 16, 1959</b> that I last saw the deceased alive on <b>June 16, 1959</b> and that death occurred at <b>7:53 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5516 Neb. Ave. - D.C.</b> DATE SIGNED <b>6/16/59</b>							
ACTUAL SIGNATURE <b>Robert B. Havell</b>		M.D. <b>5516 Neb. Ave. - D.C.</b>					
PHYSICIAN'S NAME (Type) <b>Robert B. Havell</b>		ADDRESS <b>5516 Neb. Ave., N.W. Wash. D.C.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/18/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lakewood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bowling Green, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W. Washington 9, D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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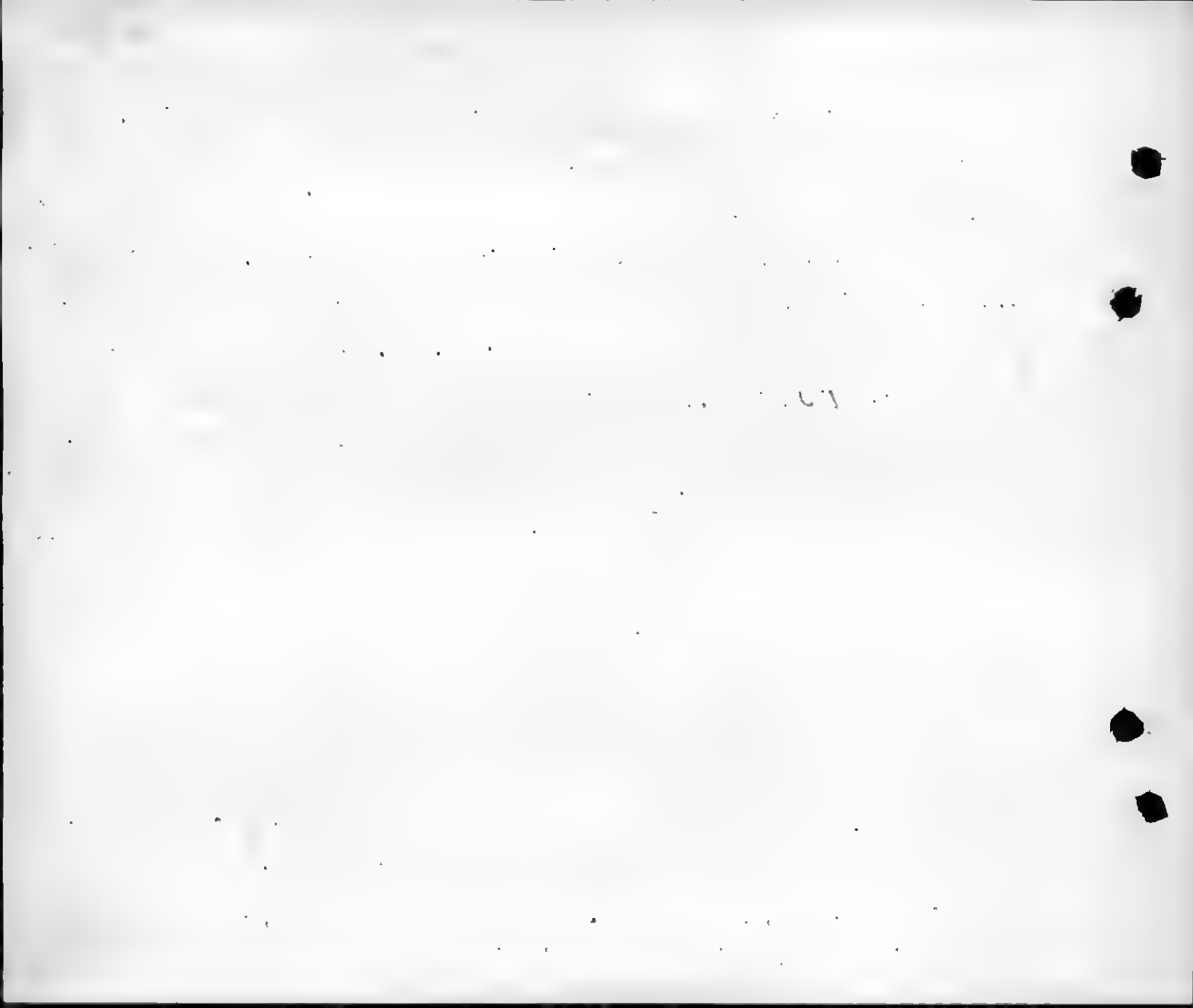
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		c. LENGTH OF STAY IN 1b <b>76 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>109 North Van Buren St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>ELIZABETH PUMPHREY HICKS</b>		4. DATE OF DEATH <b>JUNE 19 1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>30 APRIL 1883</b>
9. AGE (In years last birthday) <b>76 yrs</b>		10. IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	11. IF UNDER 24 HRS
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM REUBEN PUMPHREY</b>		14. MOTHER'S MAIDEN NAME <b>HARRIET AUGUSTA SHEKELL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>J. R. Flewcharty</b>		Address <b>Cherry Chase Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>332X</b> DUE TO <b>Arterio sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks</b> <b>25 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Renal Calculus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 1949</b> to <b>19 June 1959</b> , that I last saw the deceased alive on <b>19 June 1959</b> , and that death occurred at <b>5:15 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W S Murphy</b>		ADDRESS (Street, city or town, state) <b>615 W Montgomery Ave</b> DATE SIGNED <b>20 June 59</b>	
PHYSICIAN'S NAME (Type) <b>W S MURPHY</b>		Rockville Maryland	
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 22, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rockville Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumphrey, Inc., Silver Spring, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6962

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>XXXX.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JAMES L.</b> Middle <b>HOCKENBERRY</b> Last <b>HOCKENBERRY</b>		4. DATE OF DEATH Month <b>June 13,</b> Day <b>19</b> Year <b>59</b>	
5. SEX <b>Male</b> <b>XXXXX</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 6, 1899</b>
9. AGE (In years last birthday) <b>59</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b> Days <b>7</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Project Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ICA</b>	
11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Robert Bruce Hockenberry</b>		14. MOTHER'S MAIDEN NAME <b>Lottie Loudon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT Wife Erma Hockenberry</b> Address <b>Same as Item #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Arteriosclerosis</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>over 3 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>July 17, 1957</b> to <b>June 13, 1959</b> , that I last saw the deceased alive on <b>June 13, 1959</b> , and that death occurred at <b>9 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Warren D. Brill, M.D.</b>		DATE SIGNED <b>6-13-59</b>	
PHYSICIAN'S NAME (Type) <b>WARREN D. BRILL</b>		<b>Washington, D. C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 6-16-59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Allentown, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b>		24a. REC'D BY REGISTRAR <b>Bethesda, Md.</b>	
24b. REGISTRAR'S SIGNATURE <b>Calvin L. Hume</b>		DATE <b>JUN 16 '59</b>	

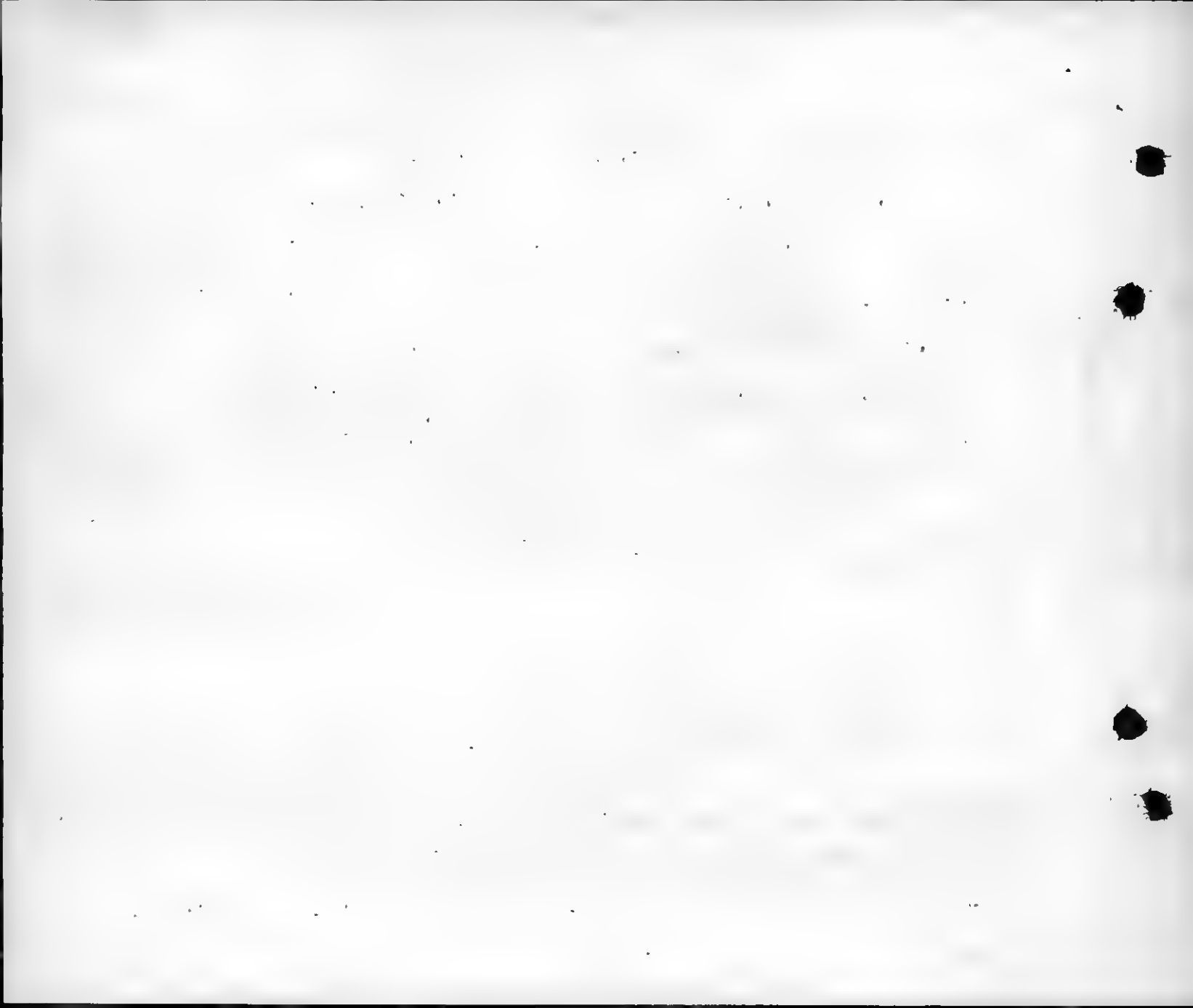
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Page 4

HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capstan permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6963

## CERTIFICATE OF DEATH

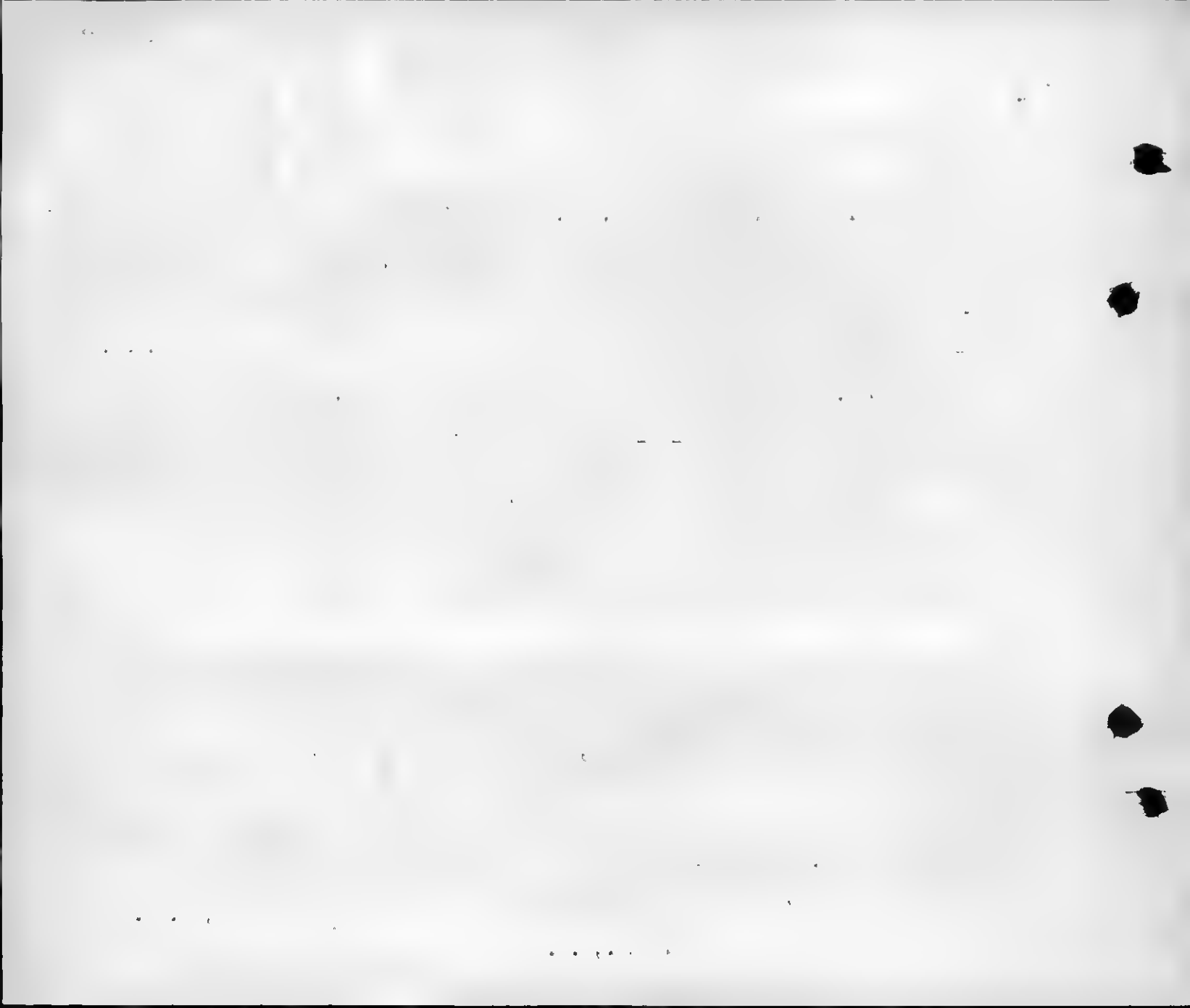
06938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>42 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b> d. STREET ADDRESS <b>5642 Cross Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Taylor</b> Last <b>Hoffman, Jr.</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 22, 1909</b>
9. AGE (In years last birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Vice-President</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aviation Supply</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert T. Hoffman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine F. Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>578-42-6661</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> <b>144X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>LUNG METASTASES - CARCINOMA</b> (c) <b>CARCINOMA OF SOFT PALATE</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 WKS</b> <b>16 MOS</b> <b>20 MOS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ACUTE PANCREATITIS</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15,</b> 19 <b>59</b> , to <b>June 26,</b> 19 <b>59</b> , that I last saw the deceased alive on <b>June 26,</b> 19 <b>59</b> , and that death occurred at <b>12:40 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>The Clinical Center</b> DATE SIGNED <b>6-26-59</b> NATIONAL INSTITUTES OF HEALTH Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/29/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Hawley, Jr.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Finner</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6964

## CERTIFICATE OF DEATH

06939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN IB <b>146 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>414 2</b> d. STREET ADDRESS <b>1475 Park Road, N. W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mabel Teresa Holland</b>		4. DATE OF DEATH Month Day Year <b>June 7, 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 13, 1898</b>
9. AGE (In years last birthday) <b>61</b> yrs		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wisconsin</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Cornelius D. Holland, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Alice Rachel Cruden</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>389-09-1503</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, secondary to obstruction of</b> <b>181.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Bladder</b> DUE TO (c) <b>Urinary tract</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 week + 1 yr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 12, 1959</b> , to <b>June 7, 1959</b> , that I last saw the deceased alive on <b>June 7, 1959</b> , and that death occurred at <b>5:20 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center 6/7/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Theodore L. Goodfriend</b> M.D.		PHYSICIAN'S NAME (Type) <b>THEODORE L. GOODFRIEND, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6-11-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>FOX LAKE CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>FOX LAKE, WISC.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>WASH. D. C.</b>		24a. REC'D BY REGISTRAR <b>JUN 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Francis J. Collins</b>			

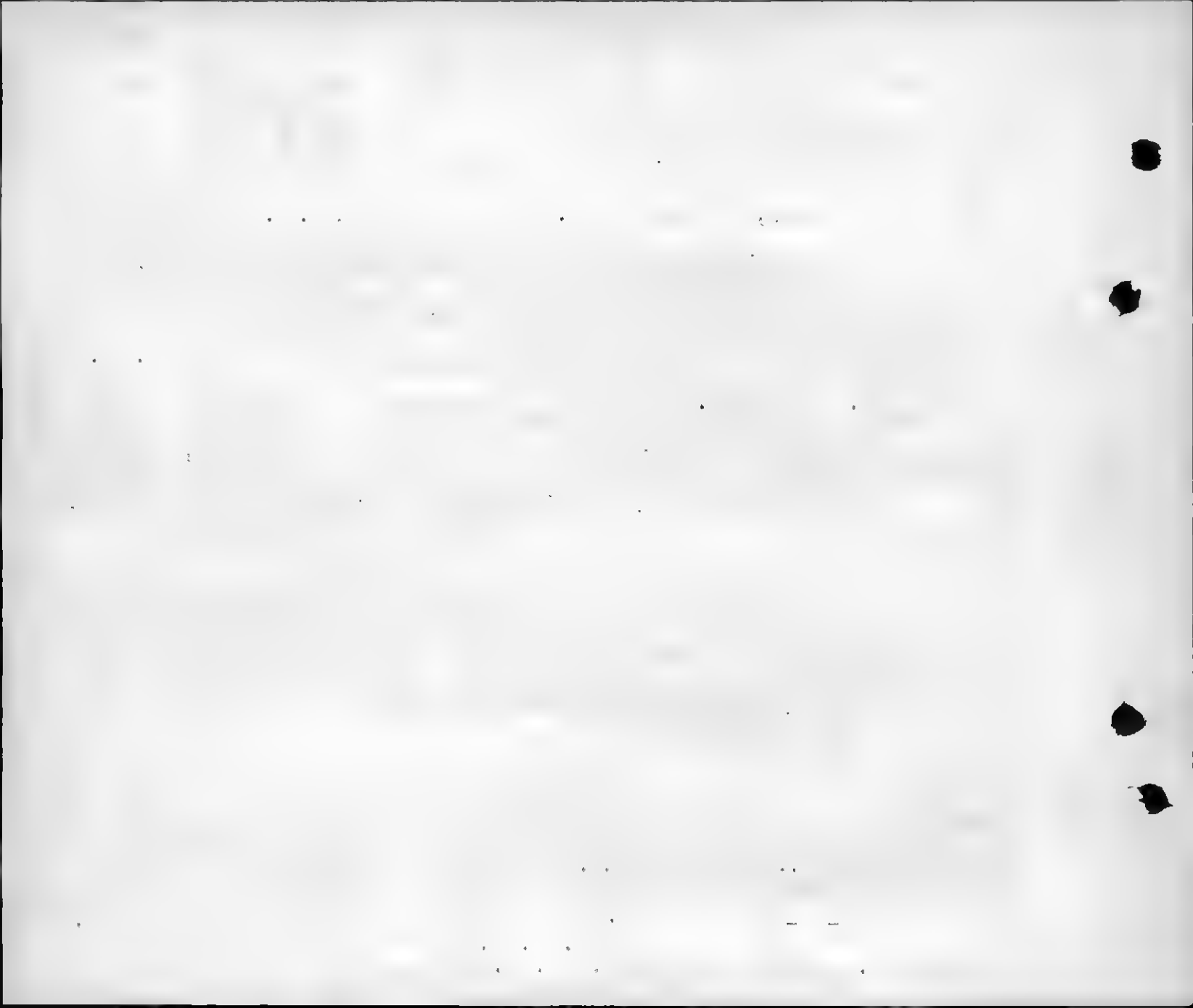
MEDICAL CERTIFICATION

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



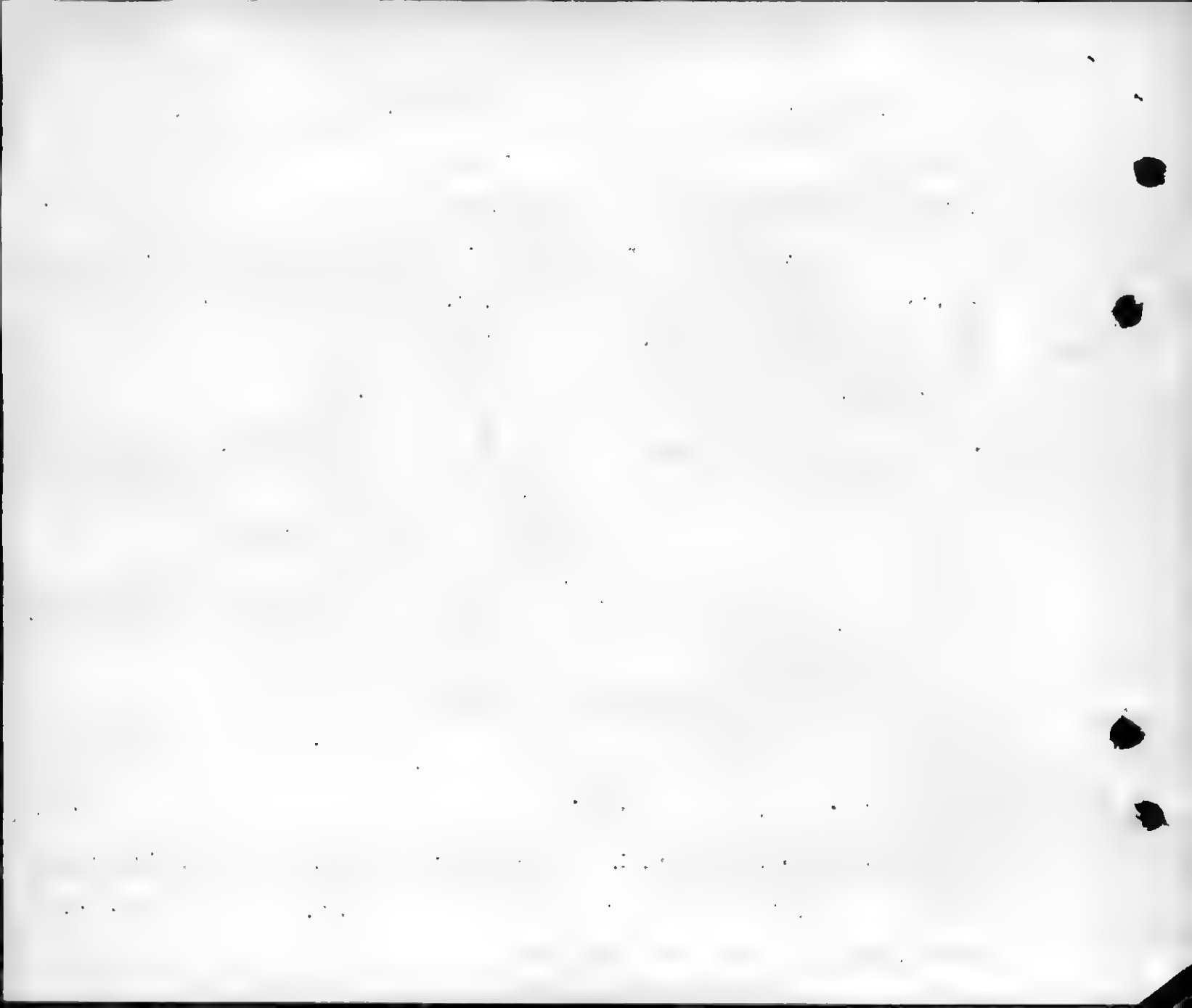
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6899 Items 8,9 Film 3244 7-8-59 et**  
**CERTIFICATE OF DEATH**

06940

Reg. Dist. No.

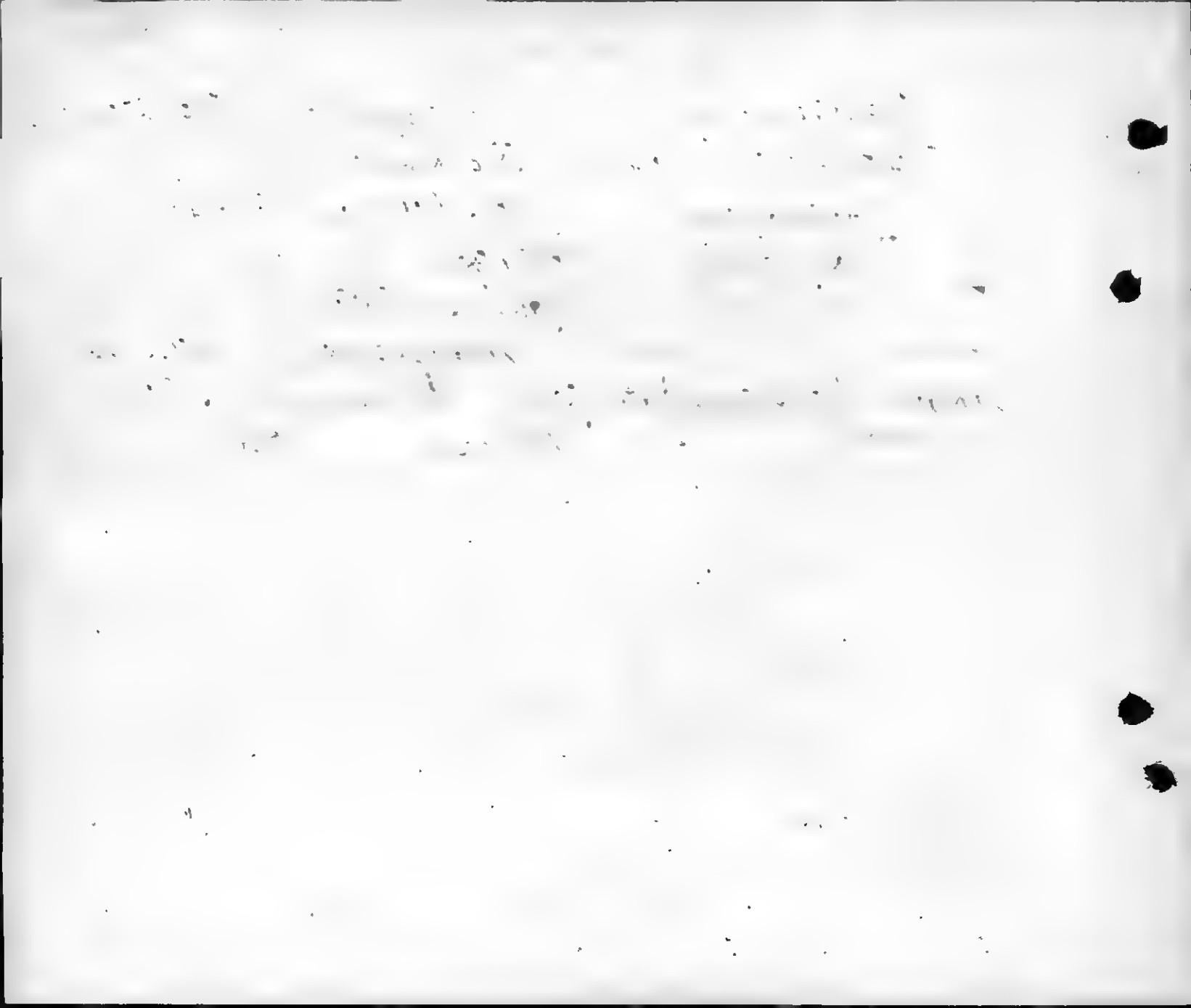
1. PLACE OF DEATH o. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1200 Clagette Drive</b>				d. STREET ADDRESS <b>1200 Clagette Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ella</b> Last <b>HOLMES</b>				4. DATE OF DEATH Month <b>June</b> Day <b>29</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8, 1956</b> <b>Jan. 27, 1956</b>		9. AGE (In years last birthday) <b>3</b> yrs	IF UNDER 1 YEAR Months <b>5</b> Days <b>2</b>	IF UNDER 24 HRS Hours <b></b> Min <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Child</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Donald Holmes</b>				14. MOTHER'S MAIDEN NAME <b>Virginia Oakes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT Address <b>Donald Holmes-Same as Item #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Malnutrition</b> DUE TO <b>congenital cardiac disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Malnutrition</b> (b) <b></b> DUE TO <b></b> (c) <b></b> DUE TO <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>Birth to death</b>	
						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 31, 1958</b> to <b>June 29, 1959</b> , that I last saw the deceased alive on <b>May 12, 1959</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Richard M. Auld</b> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <b>6/29/59</b>			
PHYSICIAN'S NAME (Type) <b>Richard M. Auld, M.D.</b>				<b>809 Viers Mill Rd. Rockville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>7/2/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Robert A. Pumphrey, Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove capstan papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.









6966

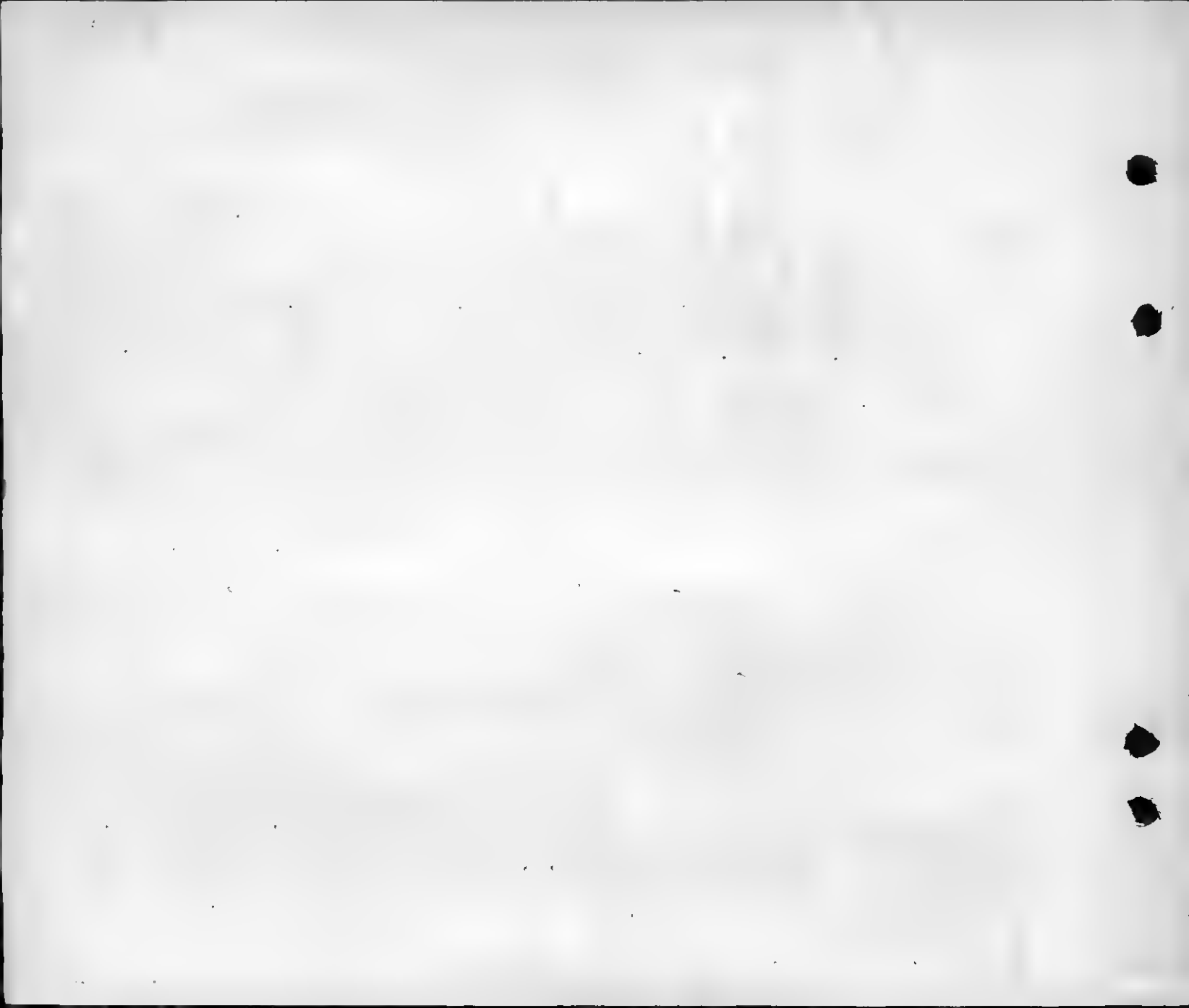
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>LeDeau Gardens Nursing Home</u>		d. STREET ADDRESS <u>3140 University Blvd.-West</u>	
3. NAME OF DECEASED (Type or print) <u>Lucy Bloodworth Inabnott</u>		4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 21, 1876</u>
9. AGE (In years lost birth day) <u>83</u> yrs		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>10</u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - U.S. Govt. - - - - -</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Georgia</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Francis W. Bloodworth</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Allen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Lucy McColloch- Item #2 - daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pituitary Exhaustion</u>			
153.8 DUE TO Partial			
(b) <u>Intestinal Obstruction, Melanoma Colon??</u>			
DUE TO (c) <u>Heart Block, Partial</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb</u> , 19 <u>59</u> to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>6:40p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert T. Thibodeau</u> M.D.		ADDRESS (Street, city or town, state) <u>10602 Concord St. Kensington, Maryland</u>	
DATE SIGNED <u>June 1, 1959</u>			
PHYSICIAN'S NAME (Type) <u>Robert T. Thibodeau, M.D.</u>		<u>Kensington, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>6-4-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Griffin, Georgia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 3 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

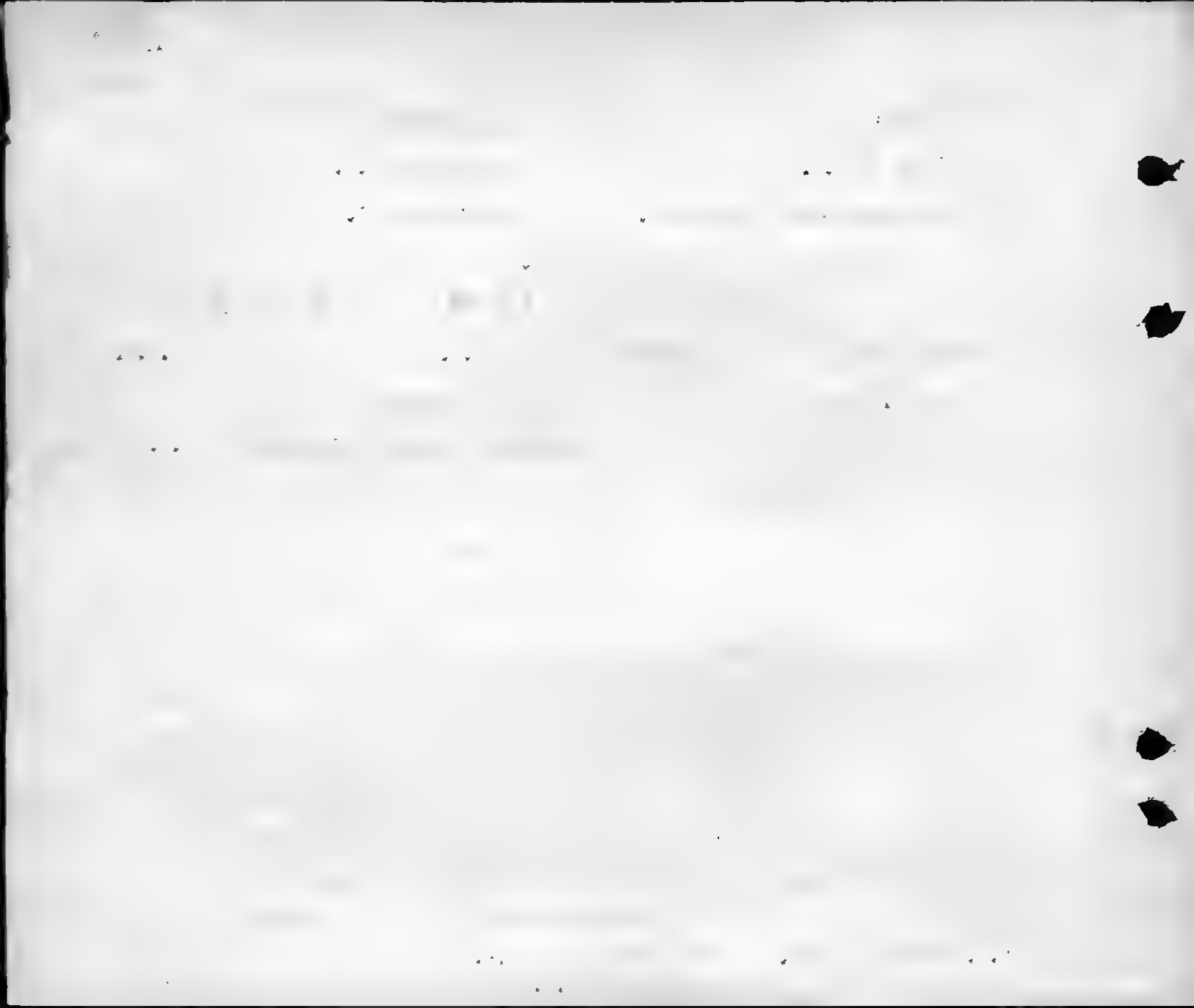
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100

06943

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>615 Roxboro Pl N.W. Takoma Park</b>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WASHINGTON SANITARIUM &amp; HOSPITAL.</b>		d. STREET ADDRESS <b>615 Roxboro Place, N.W. TAKOMA PARK MD.</b>	
3. NAME OF DECEASED (Type or print) <b>ROSE EMMA</b>		4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/8/29/88</b> 1880
9. AGE (In years (last birthday) <b>78</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min. <b>1</b>	11. IF UNDER 24 HRS Hours <b>1</b> Min. <b>1</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>JOHN K. DEAN</b>	
14. MOTHER'S MAIDEN NAME <b>SOPHIA</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <input type="checkbox"/> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO		17. INFORMANT Address <b>EDWARD A JOHNSON 615 ROXBORO PL N.W. MONTGOMERY</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute myocardial Infarction</b> DUE TO <b>Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> (c) <b>Coronary Insufficiency</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 26, 1959</b> to <b>June 26, 1959</b> , that I last saw the deceased alive on <b>June 26, 1959</b> , and that death occurred at <b>M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard F. Claggs</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7600 Carroll Ave. Takoma Park 6/26/59</b> <b>Emd</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6/30/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL CEM</b>	22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.K. HUNTEMANN &amp; SON.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>William S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06944

6967

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Northampton</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape Charles</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				e. STREET ADDRESS <u>410 Washington Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Seven</u> Last <u>Kellam</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 23, 1932</u>		9. AGE (In years last birthday) <u>26</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Factory Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unascertainable</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Linwood Kellam</u>				14. MOTHER'S MAIDEN NAME <u>Etta M. Upshur</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unavailable</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized reticulum cell sarcoma</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 11</u> , 19 <u>59</u> , to <u>June 20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 20</u> , 19 <u>59</u> , and that death occurred at <u>3:05</u> A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James M. Marsh, M.D.</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>6-21-59</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
PHYSICIAN'S NAME (Type) <u>James M. Marsh, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6-25-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Allen Mem Cem. FRANKTOWN</u>		22d. LOCATION (City, town, or county) (State) <u>VA</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>				24a. REC'D BY REGISTRAR <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6968

## CERTIFICATE OF DEATH

06945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived) If institution Residence before admission a. STATE <b>Florida</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN TB <b>33 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				e. STREET ADDRESS <b>238 San Marco Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Betty</b> Middle <b>Jane</b> Last <b>Kinlaw</b>				4. DATE OF DEATH Month <b>June</b> Day <b>12</b> , Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 6, 1927</b>	
9. AGE (In years last birthday) <b>32 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS Months Days Hours Min		12. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Florida</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Burchfield</b>				14. MOTHER'S MAIDEN NAME <b>Etta Melcher</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>410 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Rheumatic Heart Disease with Aortic and Mitral Stenosis</b> DUE TO (c) <b>Stenosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Pneumonia</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>30 Minutes</b> <b>7 Years</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 10, 19 59</b> to <b>June 12, 19 59</b> , that I last saw the deceased alive on <b>June 12, 19 59</b> , and that death occurred at <b>2:10 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Jean Donald Wilson</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>JEAN DONALD WILSON, M.D.</b>				DATE SIGNED <b>6-13-59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit</b>		22b. DATE THEREOF <b>6-13-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>San Lorenzo Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>St. Augustine, Florida</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Haines</b>	
24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>							

MEDICAL CERTIFICATION

TO HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# Item 22 11-11-59 et 6969 MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

06946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>100 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 5</u>	
f. STREET ADDRESS <u>522 Beacon Road</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael Davis Klaff</u>		4. DATE OF DEATH <u>June 7, 1959</u>	
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1955</u>
9. AGE (In years last birthday) <u>4</u> yrs		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>19</u> Min <u>59</u>	11. IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>19</u> Min <u>59</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Harvey J. Klaff</u>		14. MOTHER'S MAIDEN NAME <u>Annette Koupchik</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>The Clinical Center, Bethesda 14, Maryland</u>		Address <u>The Medical Record</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Abdominal Malignancy</u> <u>197.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <u>Malignant Mesenchymal Tumor</u> DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). INTERVAL BETWEEN ONSET AND DEATH <u>9 Months</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 27, 1959</u> , to <u>June 7, 1959</u> , that I last saw the deceased alive on <u>June 7, 1959</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>The Clinical Center Bethesda 14, Maryland</u> DATE SIGNED <u>6/7/59</u> ACTUAL SIGNATURE <u>H. R. Silberman</u> PHYSICIAN'S NAME (Type) <u>HAROLD R. SILBERMAN, M.D.</u> National Institutes of Health Bethesda 14, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-8-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) <u>Bethesda, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Danzansky &amp; Sons - 3501 14th Street, N.W.</u>		24. REC'D BY REGISTRAR <u>Arthur S. K...</u>	
24b. REGISTRAR'S SIGNATURE		DATE <u>JUN 9 '59</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

06947

Reg. Dist. No.

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Nea</u> Middle <u>O.</u> Last <u>Knight</u>		4. DATE OF DEATH Month <u>6</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/25, 1897</u>
9 AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11 BIRTHPLACE (State or foreign country) <u>Oshtemo, Iowa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>William Eastburn</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Robertson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17 INFORMATION <u>Lloyd E. Knight</u>		Address <u>above.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Failure -</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic Heart disease -</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 mo -</u> <u>20 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>8/1</u> _____, 19 <u>58</u> , to <u>June 16</u> _____, 19 <u>59</u> , that I last saw the deceased alive on <u>June 16</u> _____, 19 <u>59</u> , and that death occurred at _____ M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ernest A. Sarad M.D.</u>		ADDRESS (Street, city or town, state) <u>8006 New Hampshire Ave</u>	
PHYSICIAN'S NAME (Type) <u>ERNEST A. SARAD M.D.</u>		DATE SIGNED <u>6/16/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Falls Church, Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Kalley's Funeral Home Inc.</u>		ADDRESS <u>MT. Rainier Md.</u>	
24a. REG. BY REGISTRAR <u>JUN 19 59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6970

## CERTIFICATE OF DEATH

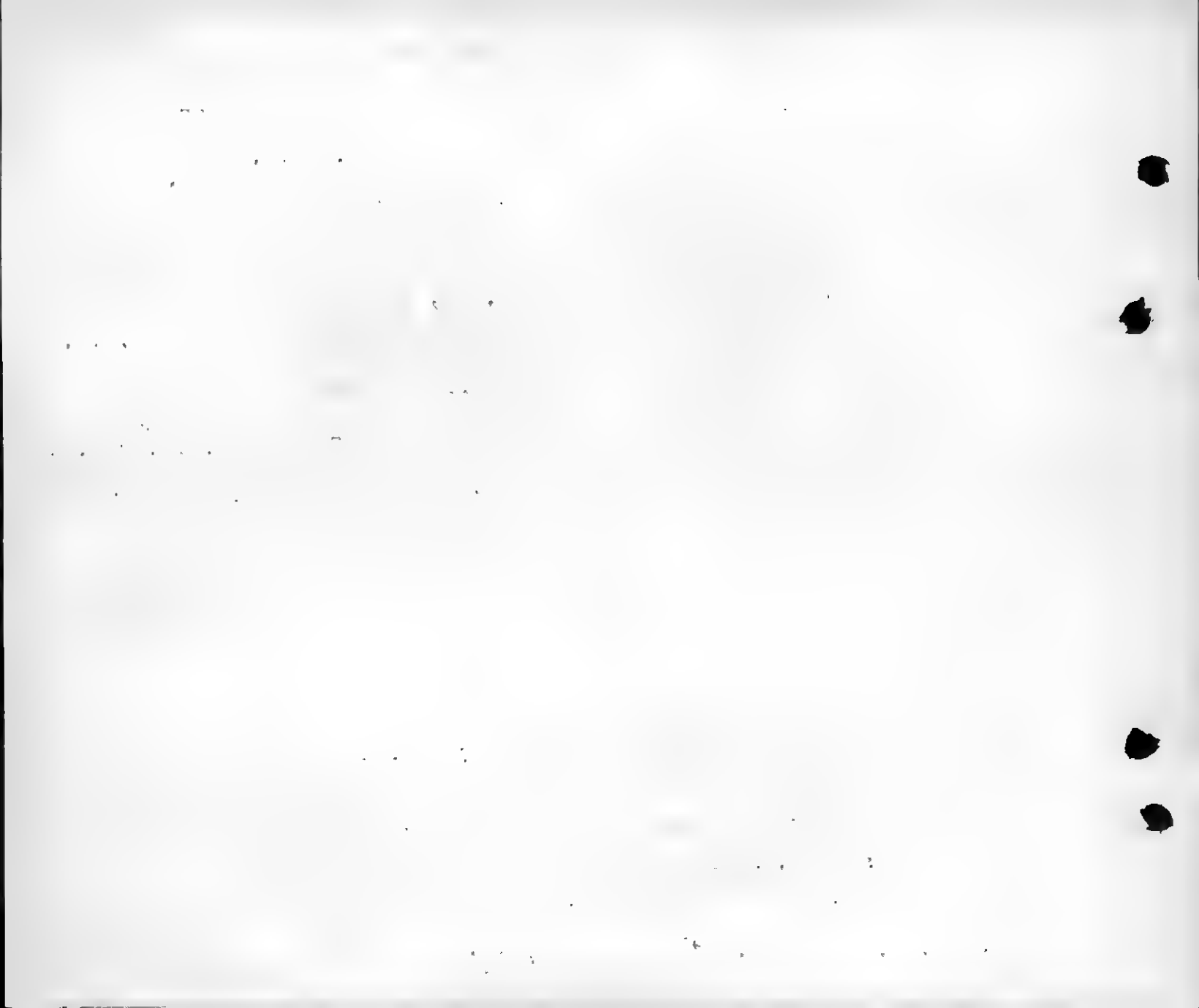
06948

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>--</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GERMANTOWN</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MARYLANDER NURSING HOME</b>		d. STREET ADDRESS <b>4852 Queen Chapel Terrace</b>	
3. NAME OF DECEASED (Type or print) First <b>NORMA</b> Middle <b>LAMBERT</b> Last <b>LAMBERT</b>		4. DATE OF DEATH Month <b>6</b> Day <b>30</b> Year <b>1959</b>	
5 SEX <b>FEMALE</b>	6 COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 11, 1878</b>
9. AGE (In years last birthday) <b>80</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>--- Jarrett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>	
17. INFORMANT <b>Forrest Lambert</b>		Address <b>4852 Queen Chapel Terrace, N.E., Wash., DC</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>4 d.d. 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>10 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10/15, 1958</b> to <b>6/30, 1959</b> , that I last saw the deceased alive on <b>6/28, 1959</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Hamascus, Md.</b> DATE SIGNED <b>6/30/59</b>			
ACTUAL SIGNATURE <b>James P. Kerr</b> M.D.		PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>7/1/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Teays Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>West Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S. H. Hines Co.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 1 '59</b>	
ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





6971

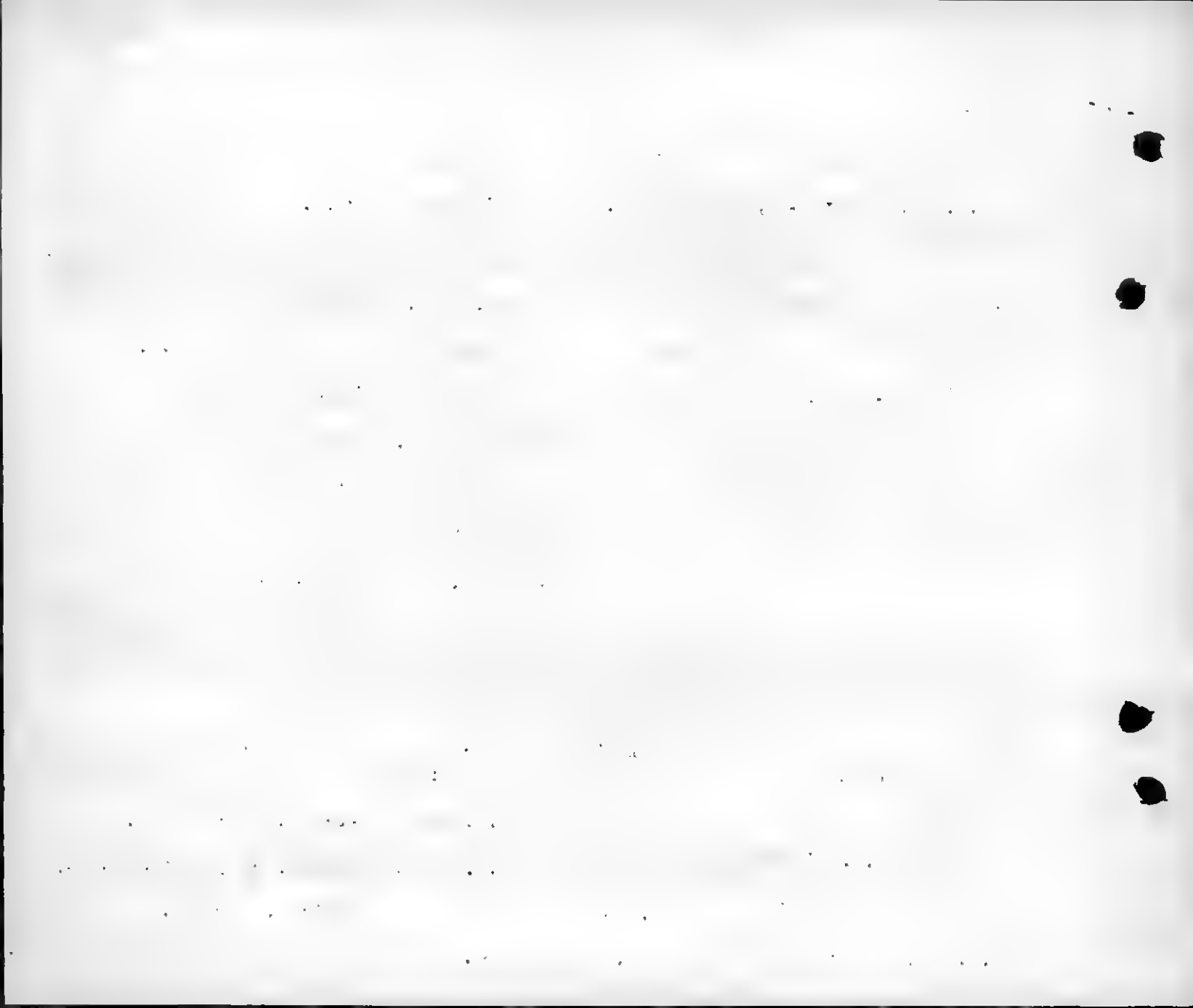
06949

CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>56 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5736 Bradley Blvd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hulda Mathilda LANGE</b>		4. DATE OF DEATH Month Day Year <b>June 9 1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 12, 1863</b>
9. AGE (In years last birthday) <b>96 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Ferdinand L. LANGE</b>		14. MOTHER'S MAIDEN NAME <b>Hulda WADAPHOHL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT (SON) George A. LANGE</b> Address <b>Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO (b) <b>atrial fibrillation</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <b>Arteriosclerotic heart disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			INTERVAL BETWEEN ONSET AND DEATH <b>24 hr</b> <b>See above</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>14 April</b> , 19 <b>59</b> , to <b>9 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9 June</b> , 19 <b>59</b> , and that death occurred at <b>8:50 A.M.</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>F.H.O. O'Connell LT MC USN</b>		M.D. <b>U.S. Naval Hospital, Bethesda Md.</b>	
PHYSICIAN'S NAME (Type) <b>F.H.O. O'CONNELL LT MC USN</b>		<b>U.S. Naval Hospital, NNMC, Bethesda Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-12-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Boniface</b>	22d. LOCATION (City, town, or county) (State) <b>Meriden, Conn.</b>
24a. REC'D BY REGISTRAR DATE <b>JUN 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

Page 4  
TO HOSPITAL OR A BOARDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



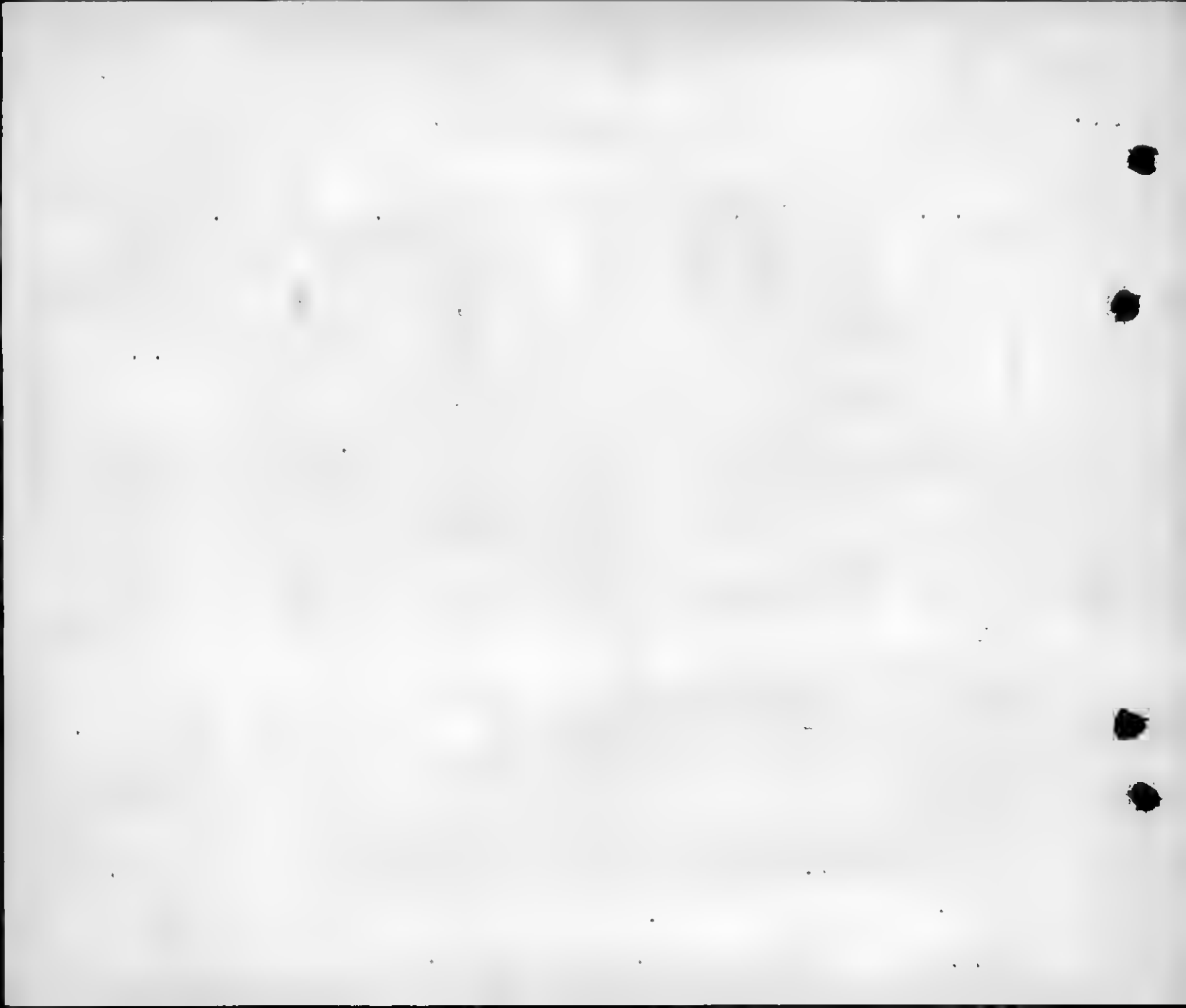
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6972 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06950

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arlington</u>	
c. LENGTH OF STAY IN 1b <u>3 days</u>		d. STREET ADDRESS <u>1101 S. Columbus Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital, NNMC</u>		e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gaye (n) LANGELLO</u>		4. DATE OF DEATH Month Day Year <u>June 6 19 59</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1917</u>
9. AGE (In years last birthday) <u>41</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Newton SUBLETTE</u>		14. MOTHER'S MAIDEN NAME <u>Bonnie LANE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>(Husband) Charles J. LANGELLO</u>		Address <u>Same as #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe necrotizing tracheitis and Bronchitis</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Etelectasis (bilateral) marked</u> DUE TO (c) <u>Inhalation of smoke</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>6 days</u> <u>6 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1st and 2nd degree burns involving extremities and trunk (7%)</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Reported clothing caught afire while smoking in bed at home</u>	
20c. TIME OF INJURY Month, Day, Year <u>6-1- 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Arlington Arlington Va.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>6-7-59</u>	
EXAMINER'S NAME (Type) <u>Frank J. BROSCHART</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/10/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forest Glen Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thoms</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>			





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# SALARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6974

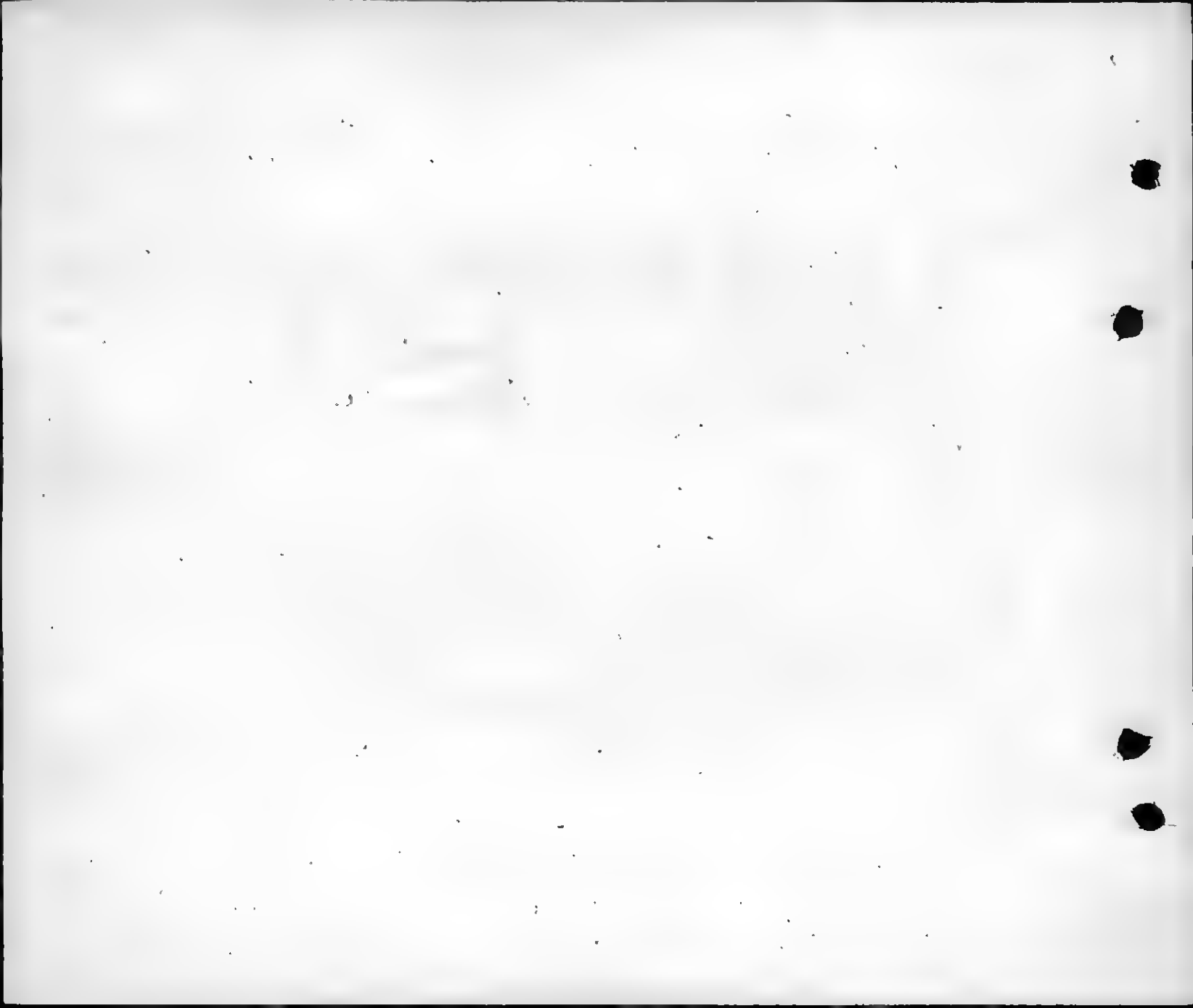
Item 12 Film 4-43 6-15-59 at

## CERTIFICATE OF DEATH

06952

Reg. Dist. No.

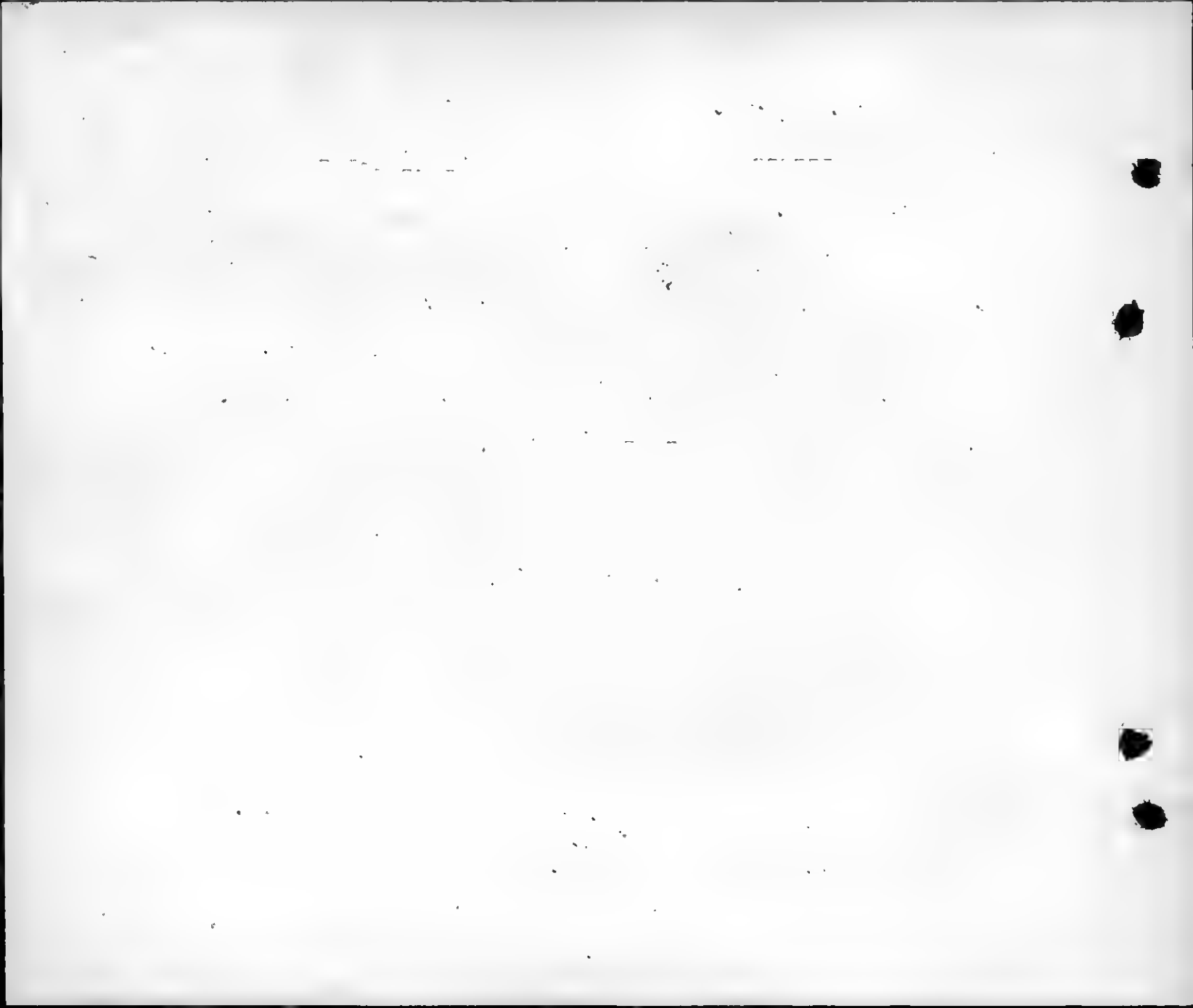
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>3 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>				e. STREET ADDRESS <u>814 Forest GLEN Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>FERRUCCIO</u> Middle <u>—</u> Last <u>LAZZARI</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/31/18</u>	9. AGE (In years last birthday) <u>41</u> yrs.	IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u>	IF UNDER 24 HRS Hours <u>1</u> Min <u>18</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery</u>		11. BIRTHPLACE (State or foreign country) <u>Bologna ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>No Italy</u>	
13. FATHER'S NAME <u>FRANCESCO LAZZARI</u>				14. MOTHER'S MAIDEN NAME <u>Ferdinando Rolle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>20-3254</u>		INFORMANT <u>Fred Lazzari</u>		Address <u>814 Forest Glen Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC STANDSTILL</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>COMPLETE HEART BLOCK</u> DUE TO (c) <u>CORONARY ATHEROSCLEROSIS INFARCTION WITH MYO-ARDIA</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>2 HRS</u> <u>17 YEARS</u>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>JUNE 5</u> , 19 <u>59</u> , to <u>JUNE 5</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 5</u> , 19 <u>59</u> , and that death occurred at <u>2 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>10620 GEORGIA AVE.</u> DATE SIGNED <u>Edward A. Beeman</u> M.D.							
ACTUAL SIGNATURE <u>Edward A. Beeman</u>		PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN, MD.</u> <u>SILVER SPRING, MARYLAND</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery Co. Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>W W Chambers</u>		ADDRESS <u>1400 Chapin St NW</u>		24a. REC'D BY REGISTRAR <u>JUN 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	





Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>7 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Walter</u> Last <u>Lewis</u>		4. DATE OF DEATH <u>June 27, 1959</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/7/1905</u>
9. AGE (In years lost birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Leonard H. Lewis</u>	
14. MOTHER'S MAIDEN NAME <u>Minnie Lascellette</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>577-05-7159</u>		17. INFORMANT <u>Clara Lewis</u> Address <u>Chovy Chase, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Thrombosis</u> (c) <u>Coronary Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>1 1/2 hrs</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 26, 1959</u> to <u>June 27, 1959</u> , that I last saw the deceased alive on <u>June 26, 1959</u> , and that death occurred at <u>12:45</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Charles W. Humphreys, M.D.</u>		DATE SIGNED <u>1746 K St. N.W.</u>	
PHYSICIAN'S NAME (Type) <u>Charles W. Humphreys, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>6/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Newport News, Virginia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>S. H. Hines Co.</u>		24. REGISTRAR'S SIGNATURE <u>Clara E. Hines</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6976

## CERTIFICATE OF DEATH

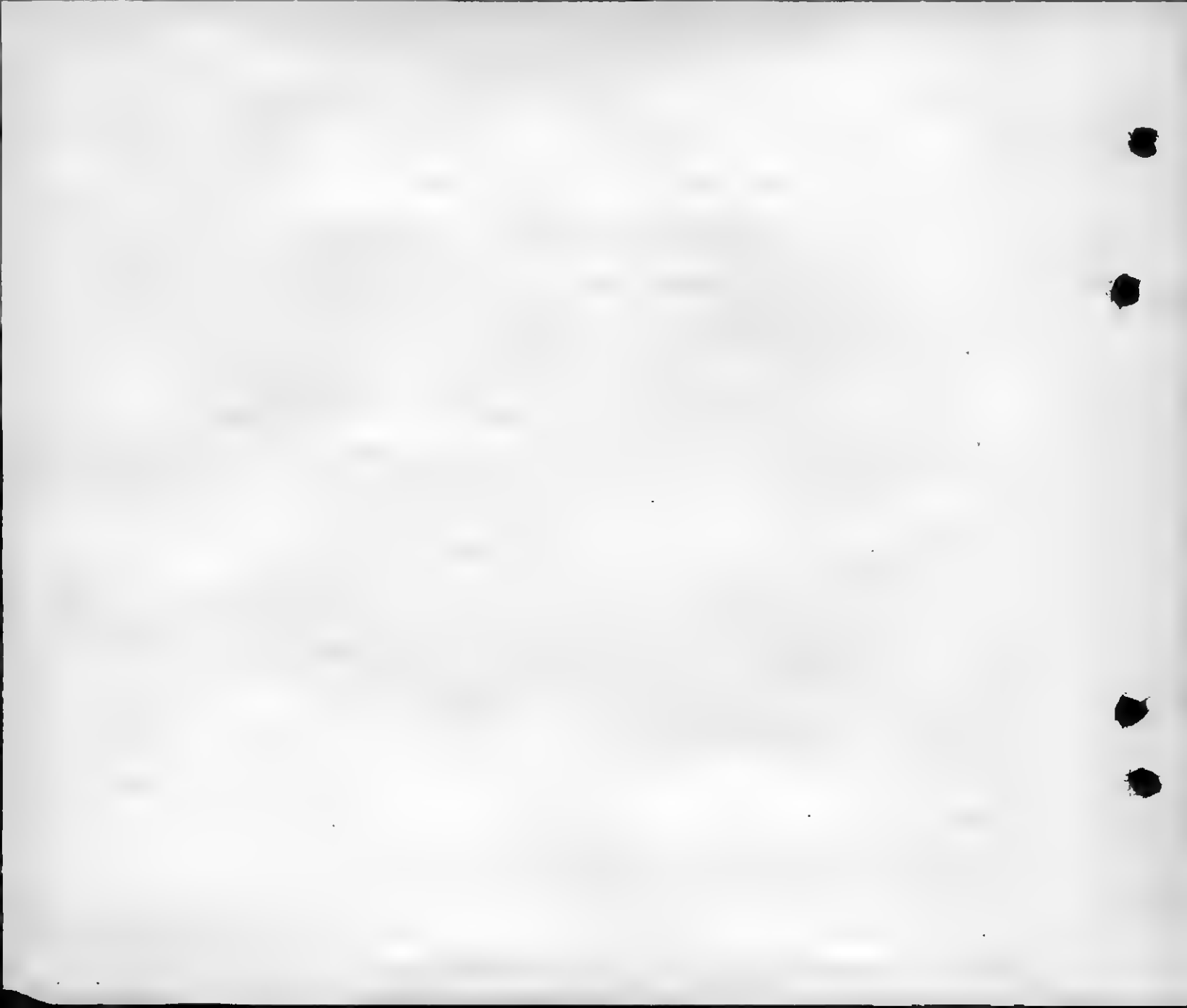
06954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bradley Hills Md. (Bethesda)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>707 Ashmont Ct.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Pauline</u> Middle <u>A</u> Last <u>Littell</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 25, 1878</u>	
9. AGE (In years last birthday) yrs. <u>78</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>		11. BIRTHPLACE (State or foreign country) <u>New York City N.Y.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Henry Seeger</u>		14. MOTHER'S MAIDEN NAME <u>Pauline Hochner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William E. E. 115704 Radnor Ct.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Hemorrhage</u> DUE TO <u>401-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aortic Stenosis</u> DUE TO <u>Myocarditis</u> (c) <u>Myocarditis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u> <u>6 Days</u> <u>6 Days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>April 3, 1957</u> to <u>June 12, 1957</u> , that I last saw the deceased alive on <u>June 12, 1957</u> , and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John L. De Mayo M.D.</u>				ADDRESS (Street, city or town, state) <u>5632 Bradley Blvd. Bethesda, Md.</u>			
PHYSICIAN'S NAME (Type) <u>John L. De Mayo</u>				DATE SIGNED <u>June 15, 1957</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>SHIRAZ</u>		22b. DATE THEREOF <u>June 15, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>GREENWOOD CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BROOKLYN NEW YORK</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. W. Chambers Co</u>				ADDRESS <u>3072 N. St. N.W.</u>		24a. REC'D BY REGISTRAR <u>Arthur E. Thomas</u>	
24b. REGISTRAR'S SIGNATURE				DATE <u>JUN 16 '59</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician, after the certificate has been signed by him, must file it with the funeral director. After the page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove ~~other~~ papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

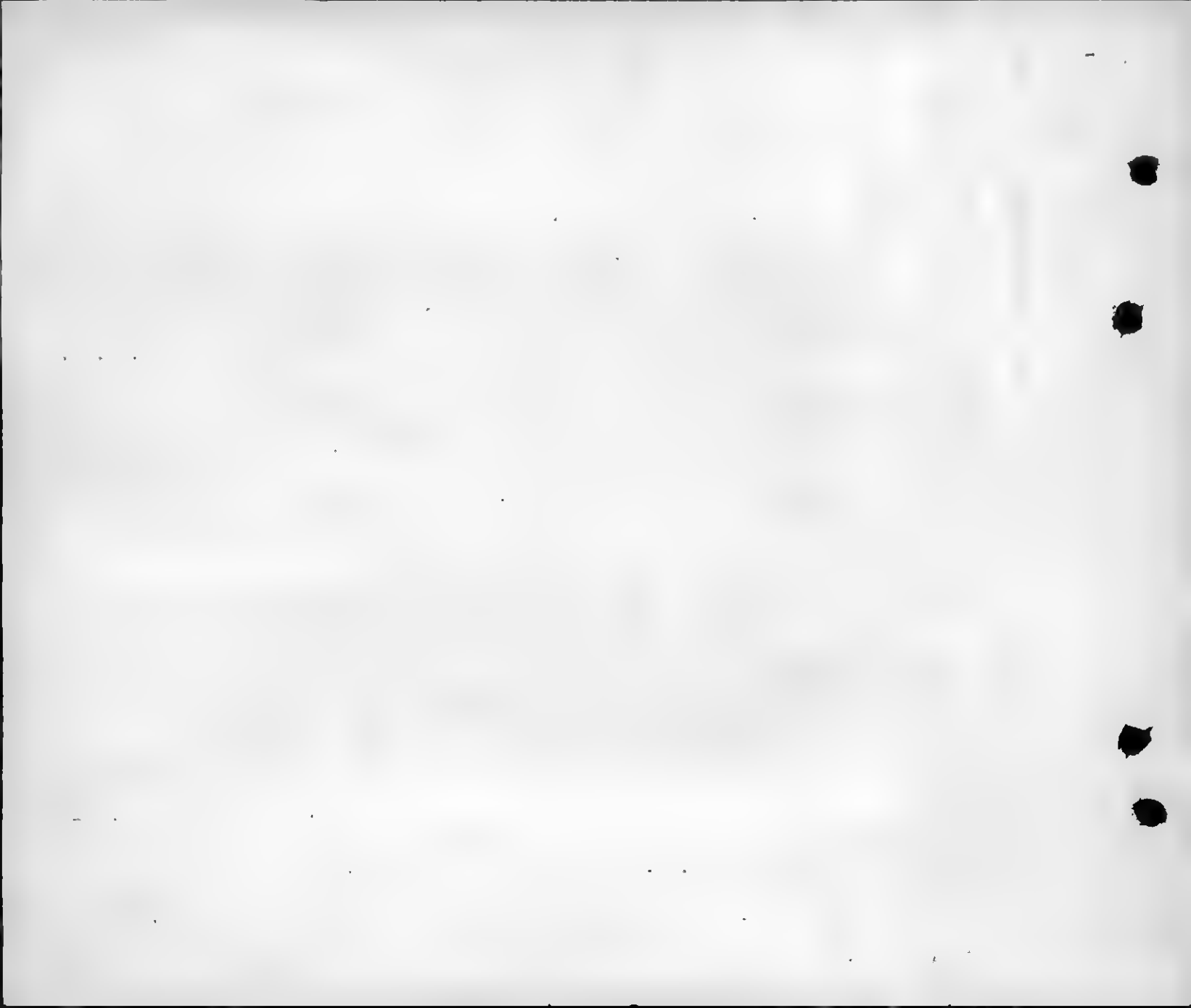
6977

## CERTIFICATE OF DEATH

06955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Alaska</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN TB <b>105 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ketchikan</b>			
f. STREET ADDRESS <b>2713 Tongass Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lucinda</b> Middle <b>-</b> Last <b>MacDonald</b>				4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 1, 1953</b>	
9. AGE (In years last birthday) <b>5</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Alaska</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Joseph MacDonald</b>				14. MOTHER'S MAIDEN NAME <b>Joanne O'Neil</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>aplastic anemia</b> <b>2.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hemolytic crisis, 2nd to 6-1</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>mos.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>March 15</b> , 19 <b>59</b> , to <b>June 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>3:07 A</b> M, from the causes and on the date stated above ACTUAL SIGNATURE <b>Leonard Garren Fox</b> H.R. Silberman PHYSICIAN'S NAME (Type) <b>Leonard Garren, M. D.</b> ADDRESS (Street, city or town, state) <b>The Clinical Center, Bethesda 14, Maryland</b> DATE SIGNED <b>6-28-59</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>July 6, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ketchikan Cemetery Ketchikan, Alaska</b>	
22d. LOCATION (City, town, or county) (State) <b>Alaska</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. CHAMBERS CO. N.W. Wash. D.C.</b>				24a. REC'D BY REGISTRAR <b>JUN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and taken to the burial-transit permit. Then please remove carbon paper. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

6900 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 2 Filed 6-15-59 et  
CERTIFICATE OF DEATH 06956

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY in 1b <b>6 yrs</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville/ Washington, D. C.</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>WAVERLY SANITARIUM</b>		d. STREET ADDRESS <b>1200 Block 16th St. N.W.</b> <b>Waverly Sanitarium</b>	
3. NAME OF DECEASED First <b>BLANCHE</b> Middle <b>MADDUX</b> Last (Type or print)		4. DATE OF DEATH Month <b>June</b> Day <b>9</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/11/1859</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>99</b> yrs
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Maddux</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Bartlett</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Cabell Maddux</b>		Address <b>4501 Chesterbrook Rd. McLeap</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>114x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Senile weakness</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>72 hours</b> <b>5 years.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>o. m.</b> Month <b>19</b> Day <b>19</b> Year <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <b>May 22, 1959</b> , to <b>June 9th 1959</b> , that I last saw the deceased alive on <b>June 9th 1959</b> , and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>W.O. Huff</b>	DATE SIGNED <b>Waverly Sanitarium 6/9/59</b>
PHYSICIAN'S NAME (Type) <b>W.O. Huff</b>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/12/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul</b>	22d. LOCATION (City, town, or county) (State) <b>Alexandria, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph J. Fowler &amp; Sons Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kiana</b>
ADDRESS <b>1756 Pa. Ave. N.W.</b>			

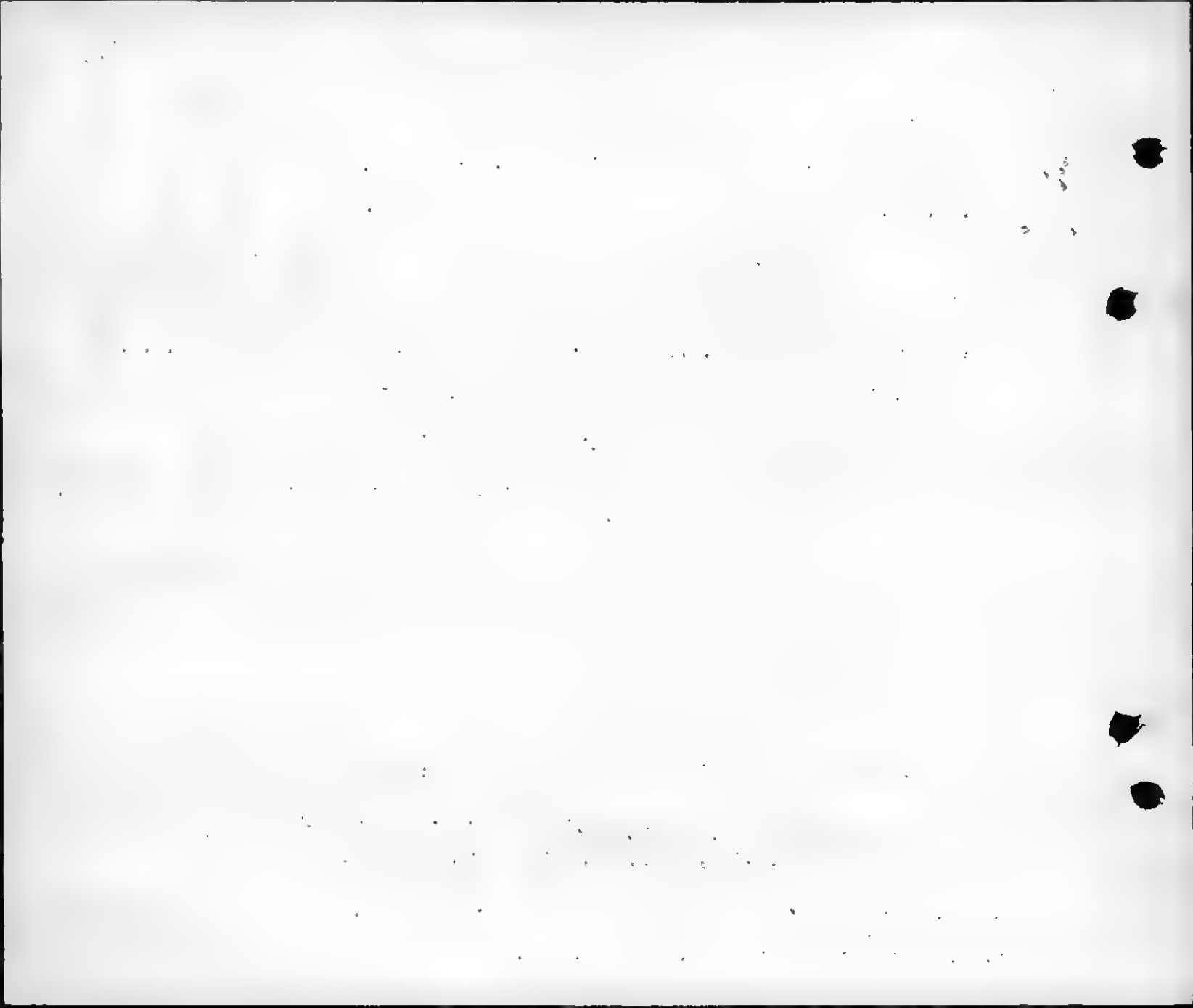




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TO HOSPITAL OR AROUNDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										06957	
6978										CERTIFICATE OF DEATH	
Reg. Dist. No. 215											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>21 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>St. Petersburg</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Petersburg</b> d. STREET ADDRESS <b>6801 46th Ave. North</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Aron</b> Middle <b>MADSEN</b> Last <b>MADSEN</b>					4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>1959</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-15-99</b>		9. AGE (In years last birthday) <b>60</b> yrs		10. IF UNDER 1 YEAR Months <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.Coast Guard</b>		11. BIRTHPLACE (State or foreign country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Harold MADSEN</b>					14. MOTHER'S MAIDEN NAME <b>Ida MATTSON</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>					16. SOCIAL SECURITY NO (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO <b>066-30-6429</b>		16. INFORMANT <b>Hospital Records</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Adenocarcinoma, rectum, with metastases to liver</b> <b>154X</b> DUE TO <b>and lungs.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____										INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a m p. m. <b>19</b>					20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>June 7</b> , 19 <b>59</b> , to <b>June 28</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 28</b> , 19 <b>59</b> , and that death occurred at <b>10:20A</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>6-29-59</b>											
ACTUAL SIGNATURE <b>Matthew W. Wood</b> M.D. PHYSICIAN'S NAME (Type) <b>Matthew W. WOOD, LCDR, MC, USN</b> <b>Bethesda, Maryland</b>											
22a. BURIAL, CREMATION, REMOVA. (Specify) <b>Burial Shipment</b>			22b. DATE THEREOF <b>6-29-59</b>			22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park Cemetery</b>			22d. LOCATION (City, town, or county) (State) <b>St. Petersburg Florida</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b> <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>						24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Orlino S. Kneass</b>			



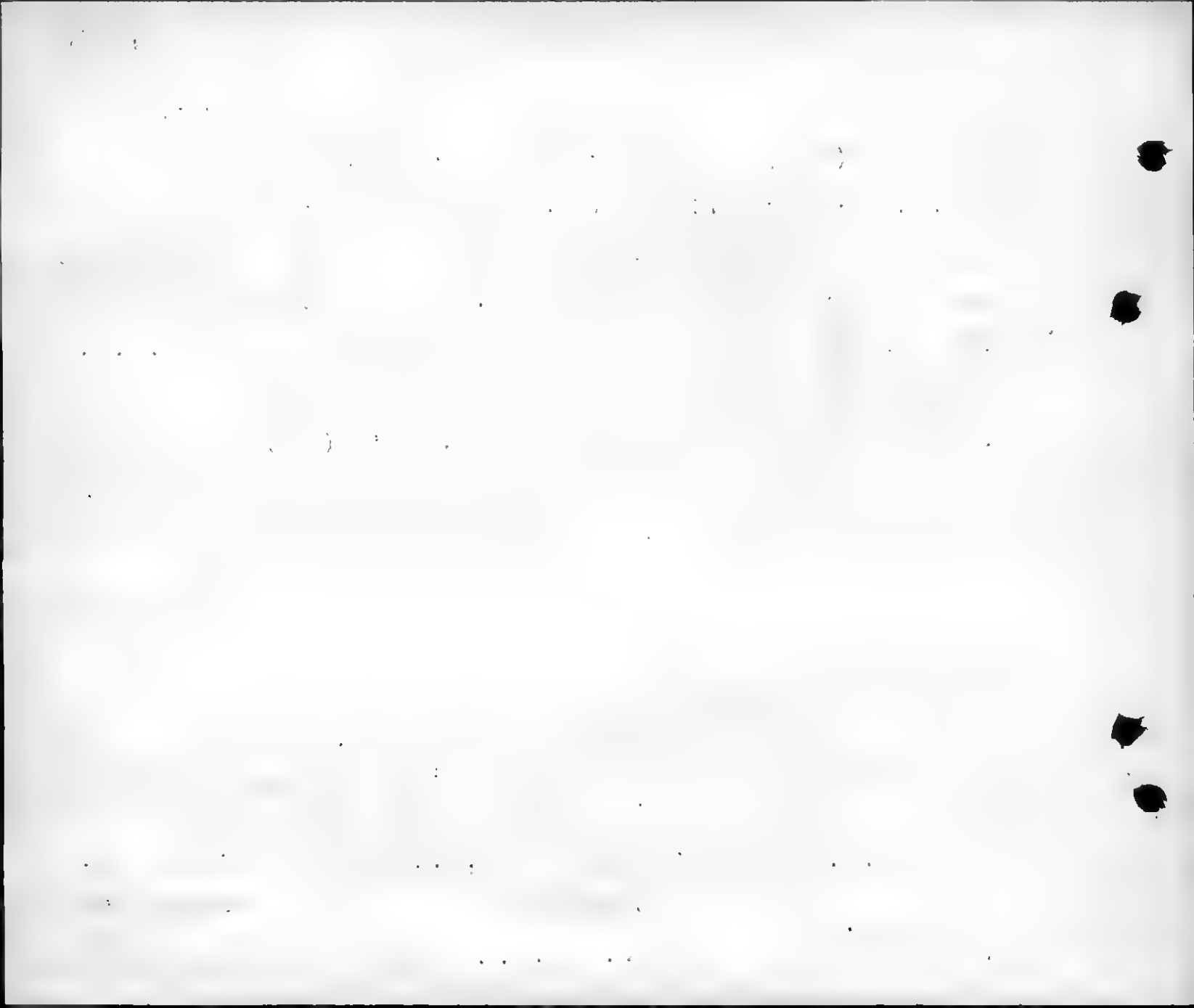
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**6979** Item 9 File #243 6-9-59 et  
**CERTIFICATE OF DEATH**

06958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>41 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Tacoma Park</b> ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital, Bethesda, Md.</b>				d. STREET ADDRESS <b>6817 Red Top Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Edward</b> Middle <b>Earl</b> Last <b>Manning</b>				4. DATE OF DEATH Month <b>June</b> Day <b>1</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 5 1901</b>	
9. AGE (In years last birthday) <b>58 yrs</b>		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min <b>59</b>		11. IF UNDER 24 HRS Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min <b>59</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Cab Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Rhode Island</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Manning</b>				14. MOTHER'S MAIDEN NAME <b>Annie Dennis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW-1</b>				16. SOCIAL SECURITY NO. <b>WW-1</b>		17. INFORMANT Address <b>Ethel A. Manning (wife)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b> 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>5+ years</b>	
						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that I attended the deceased from <b>20 April</b> , 19 <b>59</b> , to <b>1 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>1 June</b> , 19 <b>59</b> , and that death occurred at <b>9:45P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>R. G. Galbraith</b> M.D. PHYSICIAN'S NAME (Type) <b>R. G. GALBRAITH LT MC USN</b> <b>U. S. Naval Hospital, Bethesda, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>Colmar Manor Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Chambers Funeral Home</b>				24a. REC'D BY REGISTRAR <b>3072 M St. Wash. D.C.</b>		24b. REGISTRAR'S SIGNATURE <b>DATE JUN 4 '59</b>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
6980 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06959

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If Institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>5123 Manning La</u>				d. STREET ADDRESS <u>5123 Manning La</u>			
3. NAME OF DECEASED (Type or print) <u>Georgia Taliaferro Marques</u>				4. DATE OF DEATH <u>June 9 1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-21-1916</u>	9. AGE (in years last birthday) <u>42 yrs</u>	10. IF UNDER 1 YEAR Months <u>5</u> Days <u>18</u>	11. IF UNDER 24 HRS Hours <u>11</u> Minutes <u>59</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Conn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Edmund Taliaferro</u>				14. MOTHER'S MAIDEN NAME <u>Jane L. Colton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>066-10-6267</u>		17. INFORMANT <u>Paul Marques (son)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 Fat embolism</u> DUE TO (b) <u>Fatty liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>?</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs 11 min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Frank J. Brosehart</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>FRANK J. Brosehart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>6-10-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/12/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 12 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6981

## CERTIFICATE OF DEATH

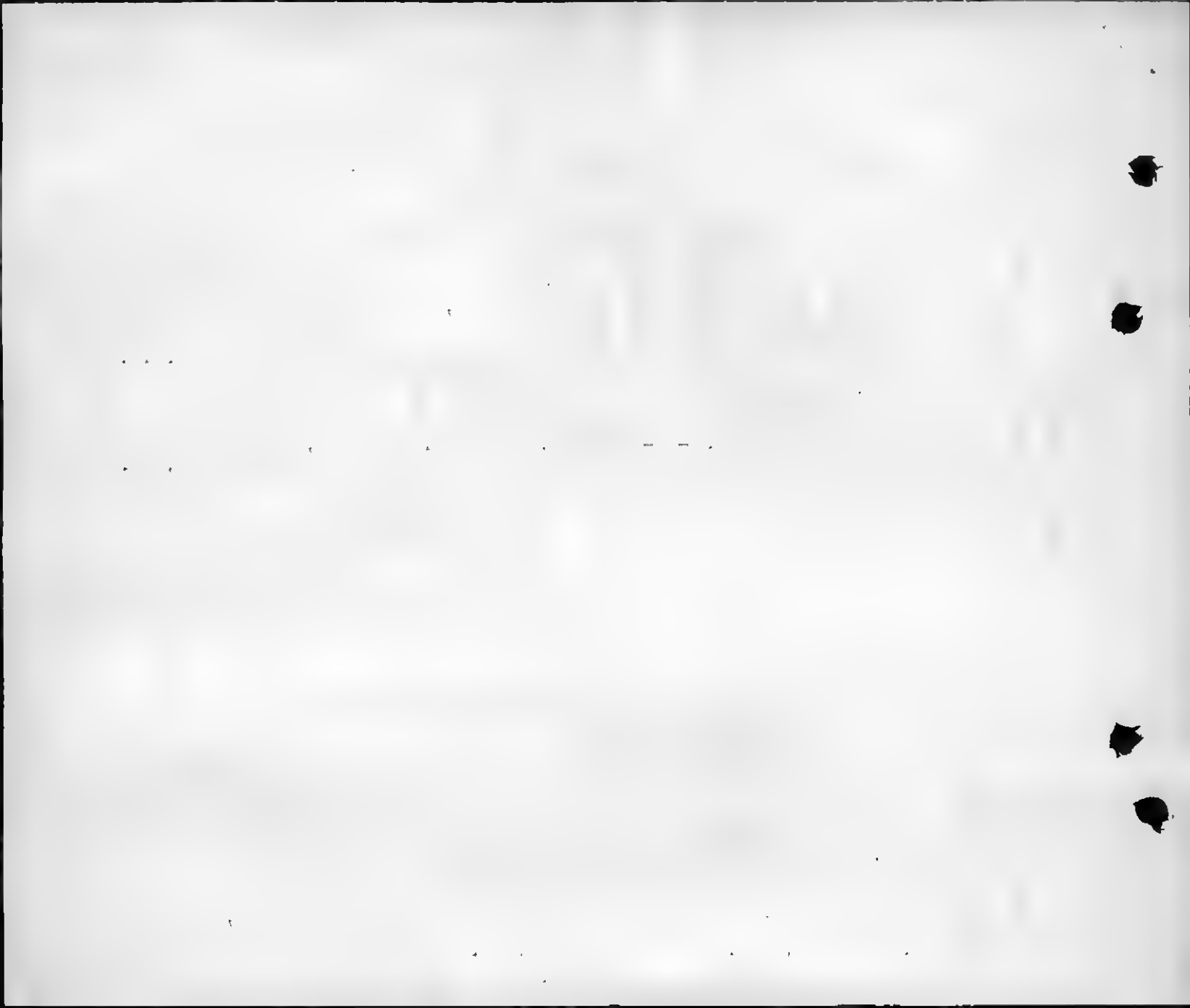
06960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COLESVILLE</b>		c. LENGTH OF STAY IN 1b <b>7 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>505 COPLEY LANE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MARJORIE C. MARSHALL</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>20</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 16, 1925</b>
9. AGE (In years last birthday) <b>33 yrs</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Minnesota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Leroy Wright Chamberlain</b>		14. MOTHER'S MAIDEN NAME <b>Hulda Wirtaen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>517-24-1732</b>	
17. INFORMANT <b>Mr. Robert C. Marshall, 505 Copley Lane</b>		Address <b>Colesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>272x</b> DUE TO <b>acute cardiac failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>secondary to pulmonary</b> DUE TO <b>cardiopathy</b> (c) <b>cardiopathy</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertension &amp; Atherosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19, 1959</b> to <b>June 20, 1959</b> , that I last saw the deceased alive on <b>June 19, 1959</b> , and that death occurred at <b>2:00 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2025 E. St. N.W.</b> DATE SIGNED <b>Alfred Brigulio</b>			
ACTUAL SIGNATURE <b>Alfred Brigulio</b>		PHYSICIAN'S NAME (Type) <b>Alfred Brigulio</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Transit &amp; burial 6/25/59</b>		22b. DATE THEREOF <b>6/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wolf Lake Village Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Wolf Lake, Minnesota</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond D. Ziska</b>		ADDRESS <b>SILVER SPRING, MD.</b>	
24a. REC'D BY REGISTRAR <b>JUN 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: If the certificate has been signed by the attending physician and completed by the funeral director, the certificate may be retained by the funeral director. If the certificate is not so completed, it should be detached from page 3 and sent to the registrar.



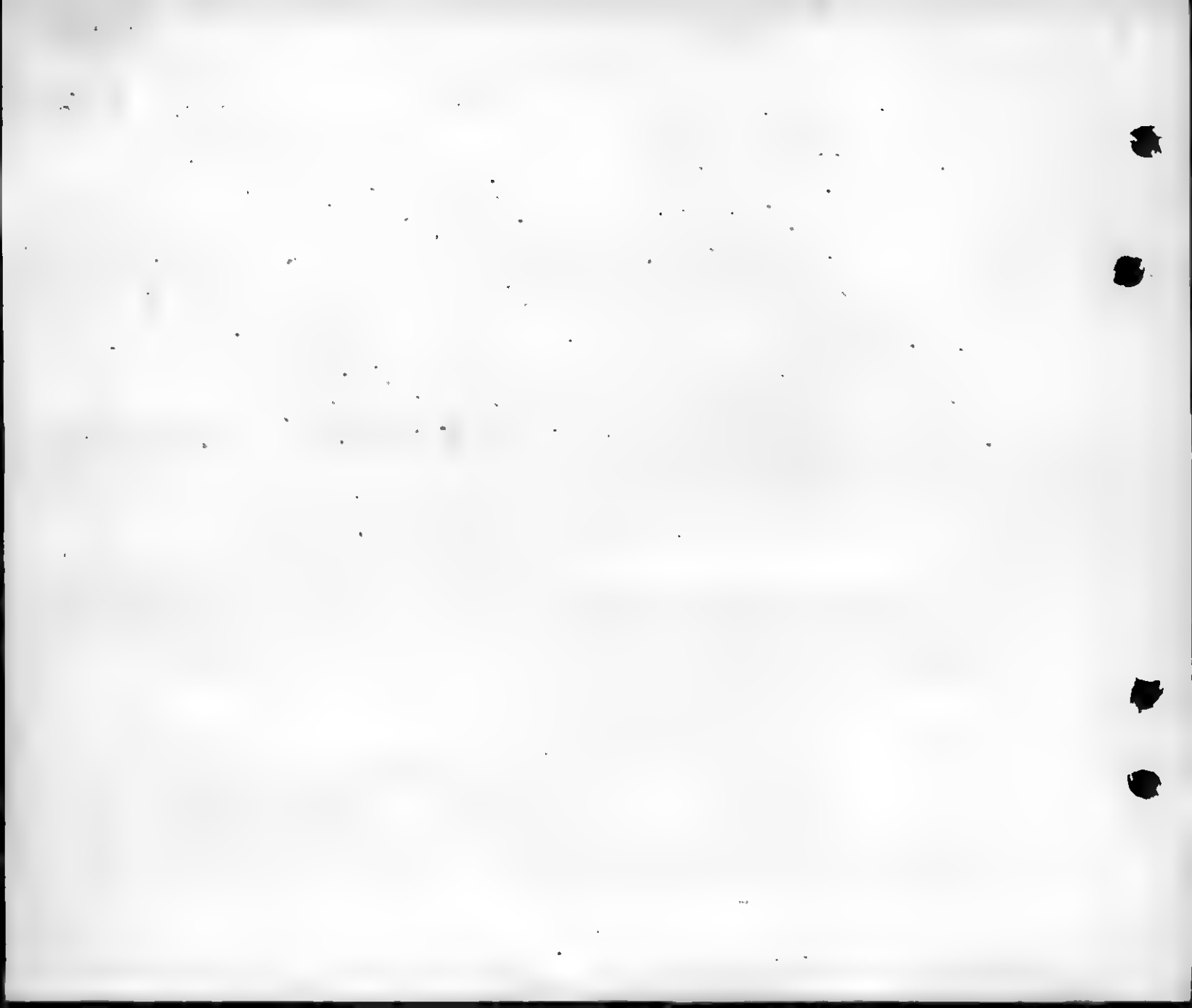


6982

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Itebbie Ann Martin</u>		4. DATE OF DEATH Month Day Year <u>June 30 1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 26, 1927</u>
9. AGE (In years last birthday) yrs. <u>32</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>	11. IF UNDER 24 HRS. Months <u>4</u> Days <u>4</u> Hours <u>4</u> Min <u>4</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Lloyd Martin</u>		14. MOTHER'S MAIDEN NAME <u>Mae Joyce</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>773.0</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 773.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hyaline Membrane Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u> <u>2 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 26</u> , 1959, to <u>June 30</u> , 1959, that I last saw the deceased alive on <u>June 29</u> , 1959, and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mabel H. Browne</u>		ADDRESS (Street, city or town, state) <u>M.D. 2203 Irving Ave, N.W.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>6/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hubert A. Snoroch - Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 6 '59</u>	
ADDRESS <u>Rockville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	



6983

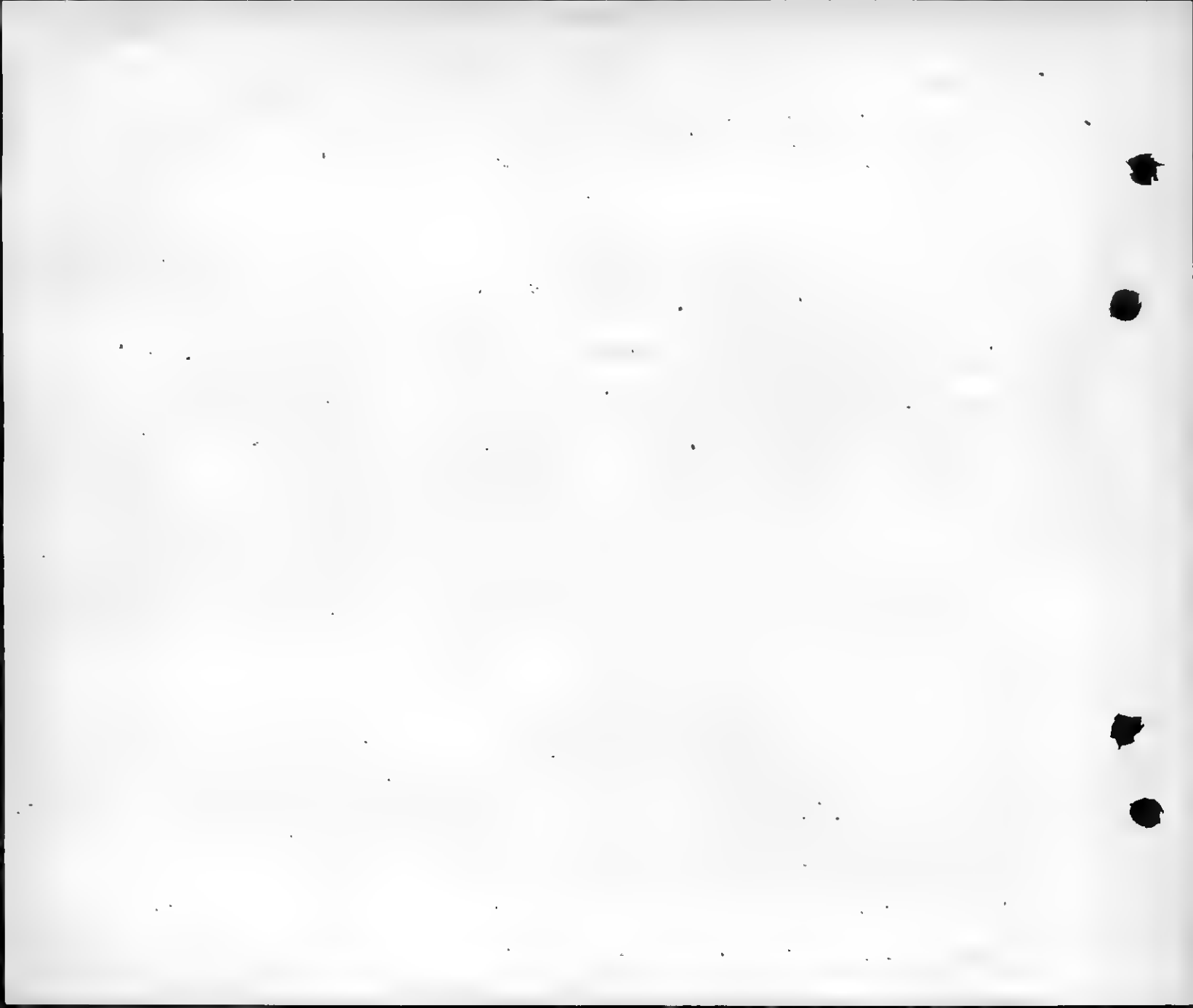
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>13012 7th Avenue</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Gertrude Agnes Martin</u>		4. DATE OF DEATH Month Day Year <u>June 15 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 8, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>9</u> Hours <u></u> Min. <u></u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13. BIRTHPLACE (State or foreign country) <u>Michigan</u>		14. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. FATHER'S NAME <u>Daniel David Butcher</u>		16. MOTHER'S MAIDEN NAME <u>Claudia Pierce</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>No</u>	
19. INFORMANT <u>Jean Collier (daughter)</u>		Address <u></u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphoma, type undetermined</u> DUE TO (b) <u></u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (c) <u></u> DUE TO (d) <u></u>			
INTERVAL BETWEEN ONSET AND DEATH <u>undet.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day, Year Hour a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u></u> , to <u>date</u> , 19 <u></u> , that I last saw the deceased alive on <u>15 June</u> , 19 <u>59</u> , and that death occurred at <u>10:29 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John G. Ball</u>		ADDRESS (Street, city or town, state) <u>Old Georgetown Rd Bethesda 14, Md.</u>	
PHYSICIAN'S NAME (Type) <u>John G. Ball</u>		DATE SIGNED <u>June 15, 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial--Trans.</u>	22b. DATE THEREOF <u>6-16-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pine Tree Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Corunna, Michigan</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>		ADDRESS <u></u>	
24a. REC'D BY REGISTRAR <u>JUN 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6984

## CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Arkansas</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Victoria</b> Middle <b>Lee</b> Last <b>MARTIN</b>				4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-6-53</b>	
9. AGE (In years last birthday) <b>5</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>		11. BIRTHPLACE (State or foreign country) <b>California</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Richard Lee MARTIN</b>				14. MOTHER'S MAIDEN NAME <b>Jeanette BOONE</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>(F) Richard L. Martin, A03, USN Sta. Memphis, Tenn</b>		Address <b>U.S. Naval Air</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congenital Heart Disease (Postoperative cardiac arrest)</b> 1745 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 15</b> , 19 <b>59</b> , to <b>June 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 25</b> , 19 <b>59</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Bethesda 14, Maryland</b> DATE SIGNED <b>6-25-59</b>							
ACTUAL SIGNATURE <b>E. J. Rupnik</b>				M. D. <b>U. S. Naval Hospital</b>			
PHYSICIAN'S NAME (Type) <b>E. J. RUPNIK, LCDR, MC, USN</b>				<b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-Shipment 6-26-59</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Monticello Arkansas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Pumphrey</b>				ADDRESS <b>Funeral Home, Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

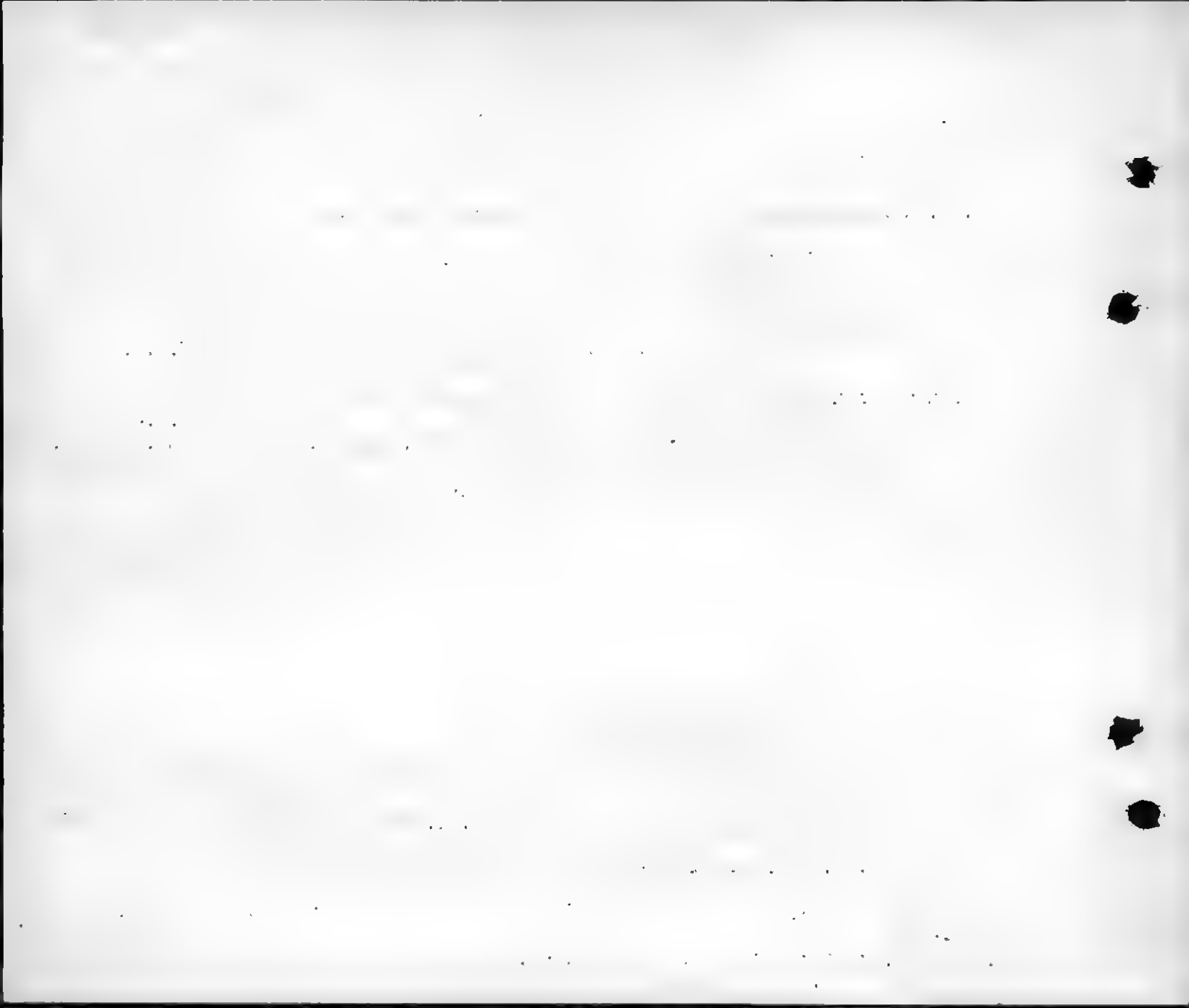
1

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

051

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VS AIS (4)  
ISM 9/58



6985

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY COUNTY MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>WASH. D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>1 yr.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9301 Weaver Street</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASH. D.C. 47X</b>			
f. STREET ADDRESS <b>2811 PENNA. AVE. S.E.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>LOUISE</b> Middle <b>B.</b> Last <b>MATTARE</b>				4. DATE OF DEATH Month <b>JUNE</b> Day <b>26</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 27, 1872</b>	
9. AGE (In years last birthday) <b>87</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Bernard Buscher</b>				14. MOTHER'S MAIDEN NAME <b>Louise Burkhardt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Son</b> <b>5702 Kirkside Dr. Chevy Chase, Md.</b> <b>Luke Mattare</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO (b) <b>HYPERTENSIVE HEART DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>AND DIABETES MELLITUS</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 MOS.</b> <b>1 YEAR</b> <b>5 YEARS</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>APRIL 29, 1959</b> to <b>JUNE 26, 1959</b> , that I last saw the deceased alive on <b>JUNE 26, 1959</b> , and that death occurred at <b>6:45 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Vincent J. DiFrancesco</b> M.D.				ADDRESS (Street, city or town, state) <b>2436 L'ENFANT SQUARE SE</b> DATE SIGNED <b>June 26/1959</b>			
PHYSICIAN'S NAME (Type) <b>VINCENT J. DiFRANCESCO</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-29-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Washington, D. C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUL 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. The first group of people who are not in the labor force are those who are not in the labor force for any reason. This group is the largest and is made up of people who are not in the labor force for any reason. This group is the largest and is made up of people who are not in the labor force for any reason.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6986 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

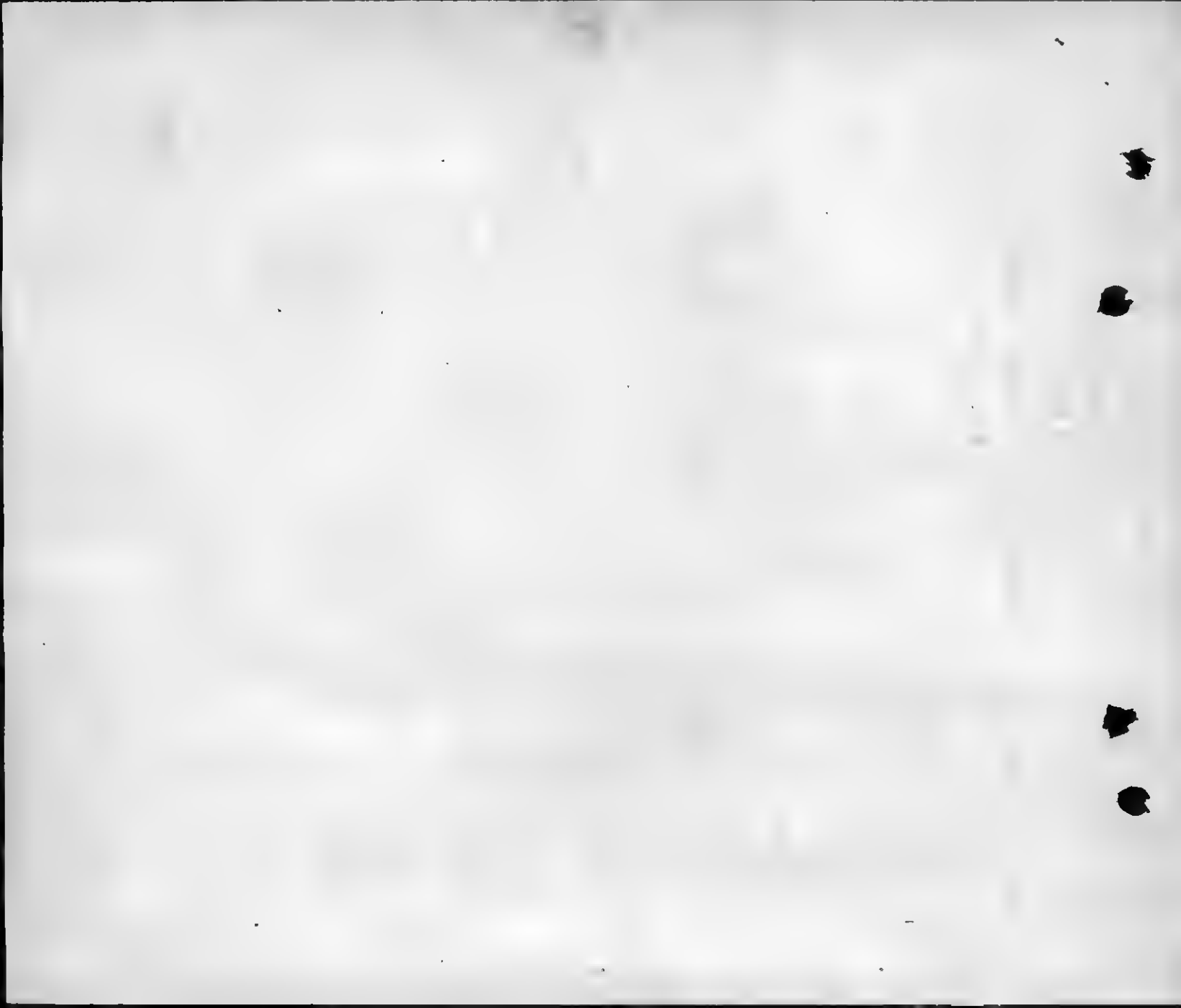
06965

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>3 ym</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, Residence before admission) a. STATE <u>md</u> b. COUNTY <u>monty</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9416 Locust Hill Rd</u>				d. STREET ADDRESS <u>9416 Locust Hill Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Richard George May Jr</u>				<b>4. DATE OF DEATH</b> Month <u>June</u> Day <u>2</u> Year <u>1959</u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug 13 1904</u>	
<b>9. AGE</b> (In years last birthday) <u>54</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>9</u> Days <u>19</u>		<b>11. IF UNDER 24 HRS</b> Hours <u></u> Min. <u></u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Kee Bus Asstt American R R</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Pa</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Pa</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Richard Lee May</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Ann Thomas</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>713-07-4180</u>		<b>17. INFORMANT</b> <u>Eleanor May (wife)</u> Address <u>Ilw 2</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of Item 18)			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m.		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschart</u>				<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschart</u>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial-Trans</u>		<b>22b. DATE THEREOF</b> <u>5/6/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Tioga Point Cemetery</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Athens, Pennsylvania</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey</u>				<b>24a. REC'D BY REGISTRAR</b> <u>JUN 8 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



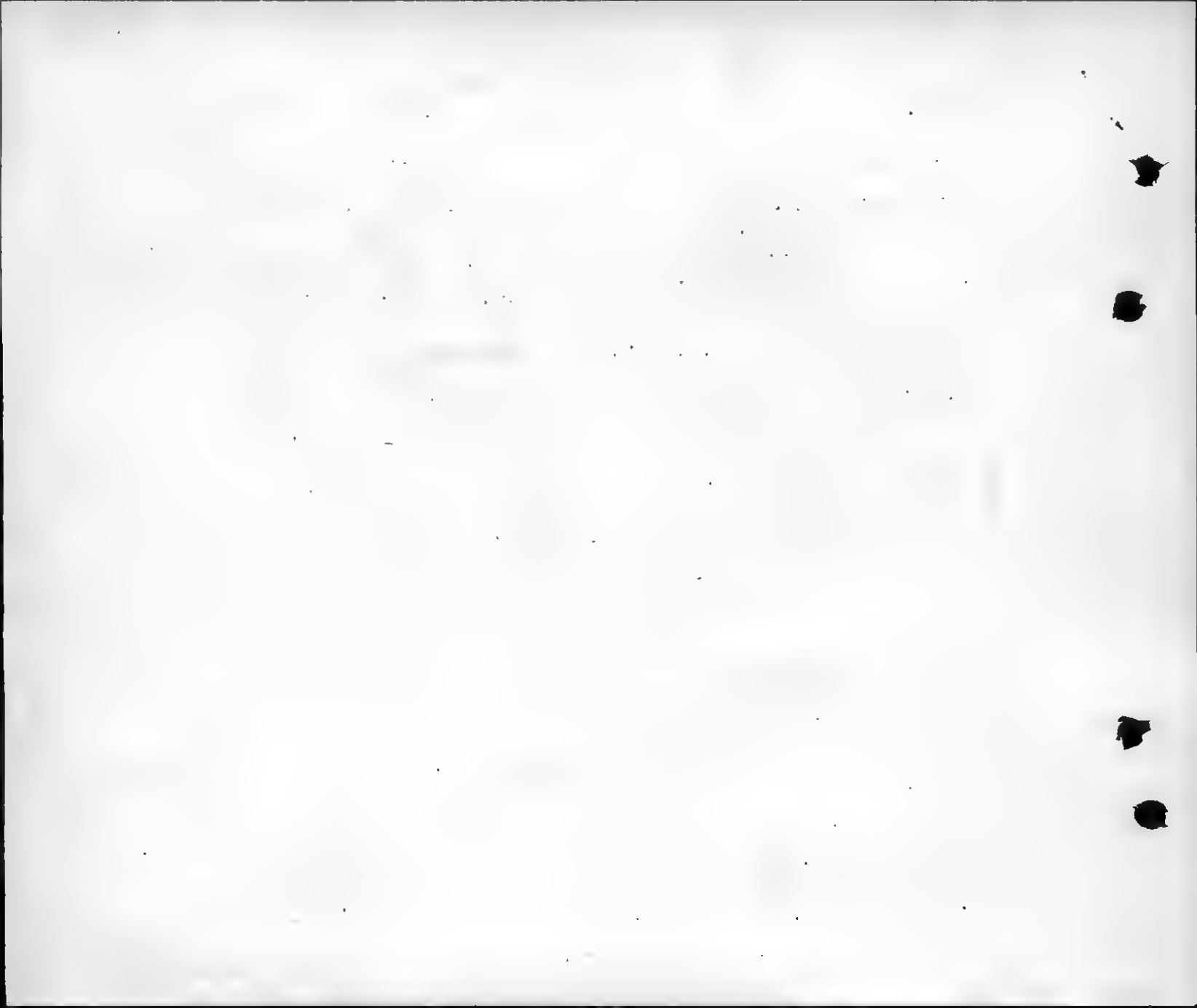
6987

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address of institution) <b>4817 DeRussey Parkway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MILBURN</b> <del>XXXXXXXXXX</del>		4. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23, 1880</b>
9. AGE (In years last birthday) yrs <b>78</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>22</b>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Leah McCarty-Item # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> DUE TO (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Coronary Thrombosis</b> DUE TO <b>Myocardial Infarction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>Unknown</b> <b>2 Months</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>None</b> p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 2, 1959</b> to <b>June 15, 1959</b> that I last saw the deceased alive on <b>June 15, 1959</b> and that death occurred at <b>4:40 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>James M. Loftus</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>June 15, 1959</b>	
PHYSICIAN'S NAME (Type) <b>James M. Loftus</b>		<b>673 Park Road N.W. Washington D.C.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>6/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 17 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hines</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6988

CERTIFICATE OF DEATH

06967

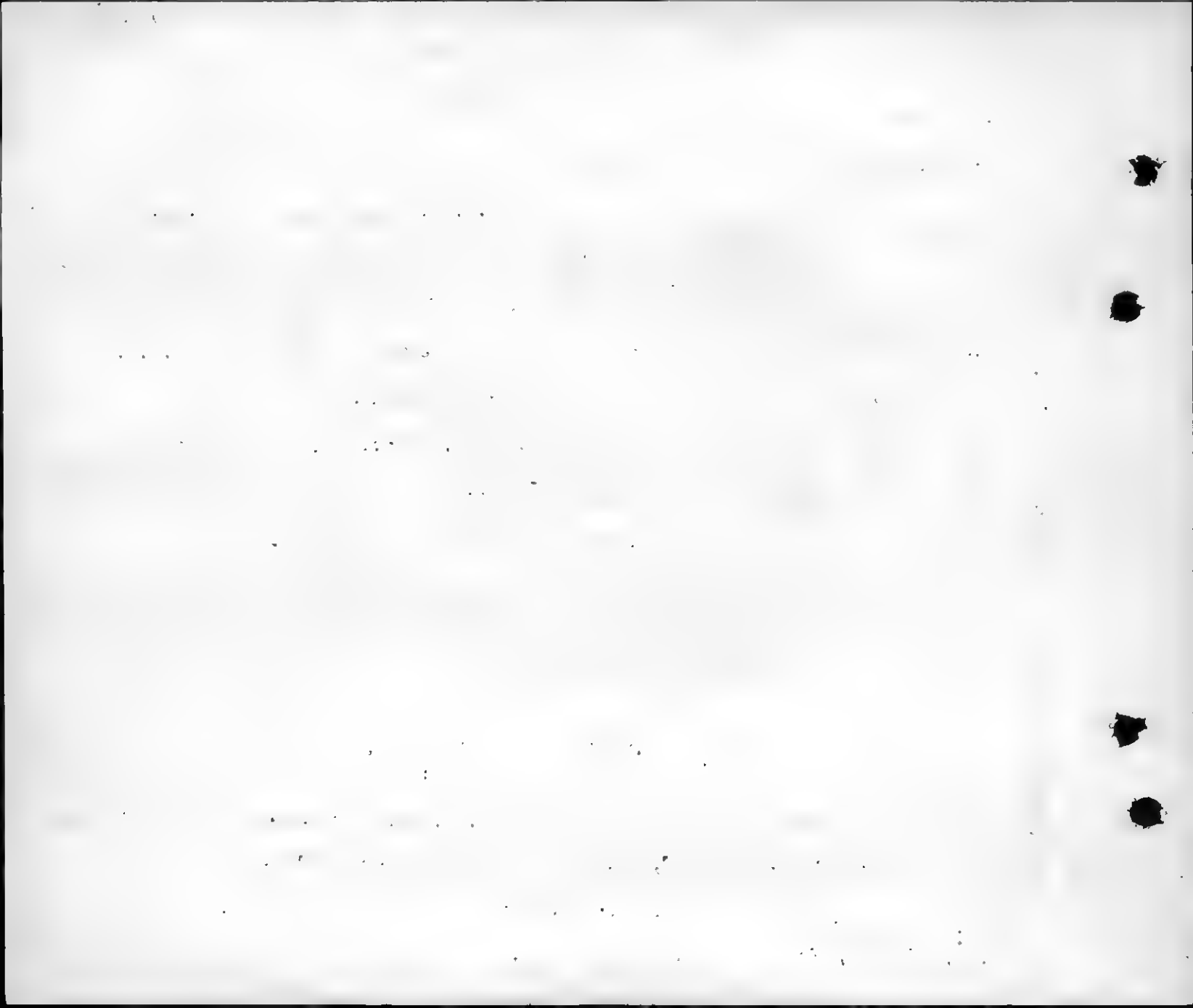
Reg. Dist. No. 215

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-57

Montgomery County Medical Examiner notified.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>24 Days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Pri. Geo. Co.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cheltenham</b>		d. STREET ADDRESS <b>U.S. Naval Radio Station - Bks. 13</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Helen</b>		Middle <b>Frances</b>		Last <b>McCoy</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>17</b>		Year <b>1959</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>Caucasian</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-25-22</b>		9. AGE (In years last birthday) <b>36</b> yrs.		IF UNDER 1 YEAR Months <b>36</b>		IF UNDER 24 HRS Days <b>36</b>		Hours <b>36</b>		Min. <b>36</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- - - -</b>				11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Franz Ortolf</b>						14. MOTHER'S MAIDEN NAME <b>Helen MacCadden</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>(H) Jack D. McCoy, same as #2 above</b>				INFORMANT <b>(H) Jack D. McCoy, same as #2 above</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Heart Failure</b> <b>7545</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Heart Disease</b> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 24</b> , 19 <b>59</b> , to <b>17 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 17</b> , 19 <b>59</b> , and that death occurred at <b>2:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>U. S. Naval Hospital</b> <b>6-17-59</b>															
ACTUAL SIGNATURE <b>Douglas R. Koth</b>				M.D. <b>U. S. Naval Hospital</b>				DATE SIGNED <b>6-17-59</b>				PHYSICIAN'S NAME (Type) <b>Douglas R. KOTH, LT, MC, USN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>6-21-59</b>				22c. NAME OF CEMETERY OR CREMATORY <b>Fernwood Memorial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland Co. New Jersey</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. A. Humphrey</b>				ADDRESS <b>R. A. Humphrey Funeral Home, Bethesda, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 22 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			



6989

## CERTIFICATE OF DEATH

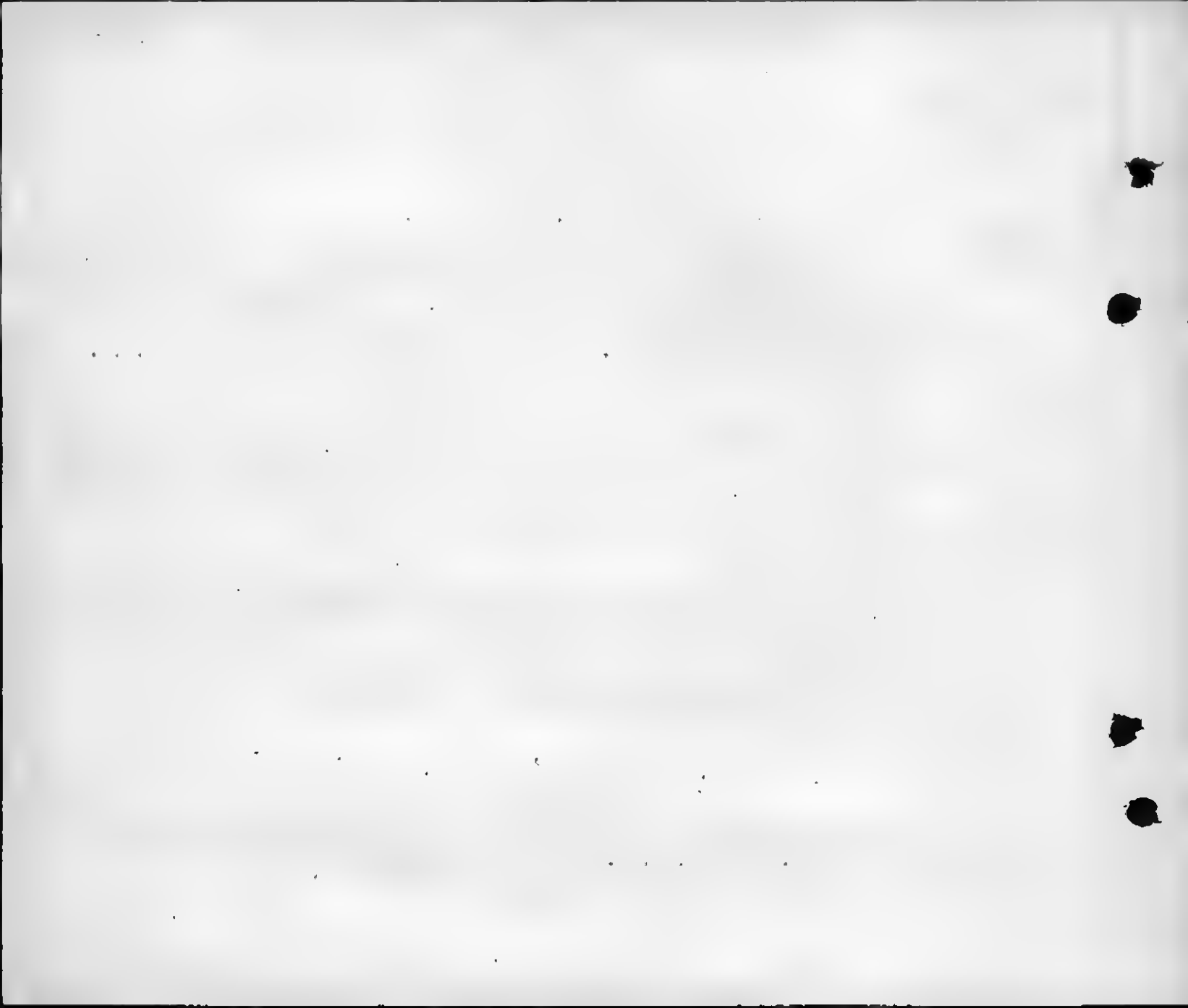
06968

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>128 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Princess Anne</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b> d. STREET ADDRESS <b>Route #1, Box 15</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lawrence</b> Middle <b>(none)</b> Last <b>McMillion</b>		4. DATE OF DEATH Month <b>June</b> Day <b>2</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1888</b>
9. AGE (In years last birthday) <b>71 yrs</b>		IF UNDER 1 YEAR Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min <b>71</b>	IF UNDER 24 HRS Months <b>71</b> Days <b>71</b> Hours <b>71</b> Min <b>71</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Night Watchman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John McMillion</b>		14. MOTHER'S MAIDEN NAME <b>Liza Smithson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration of Blood Clot + Stomach Contents</b> DUE TO (b) <b>Gastro Intestinal tract Hemorrhage</b> DUE TO (c) <b>Myeloid metaplasia with agnogenic myeloid metaplasia, myelofibrosis, hepatosplenomegaly</b> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Anterolateral Cardiovascular disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		20g. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 25, 1959</b> , to <b>June 2, 1959</b> , that I last saw the deceased alive on <b>June 2, 1959</b> , and that death occurred at <b>2:16 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Norman R. Gevirtz</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>	
PHYSICIAN'S NAME (Type) <b>Norman R. Gevirtz, M. D.</b>		DATE SIGNED <b>6-2-59</b>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-5-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Olive Branch</b>		22d. LOCATION (City, town, or county) (State) <b>Portsmouth, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee Funeral Home</b>		ADDRESS <b>Washington D.C.</b>	
24a. REC'D BY REGISTRAR <b>JUN 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





1

INSTRUCTIONS

TO ATTENDING PHYSICIAN: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and properly filed in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

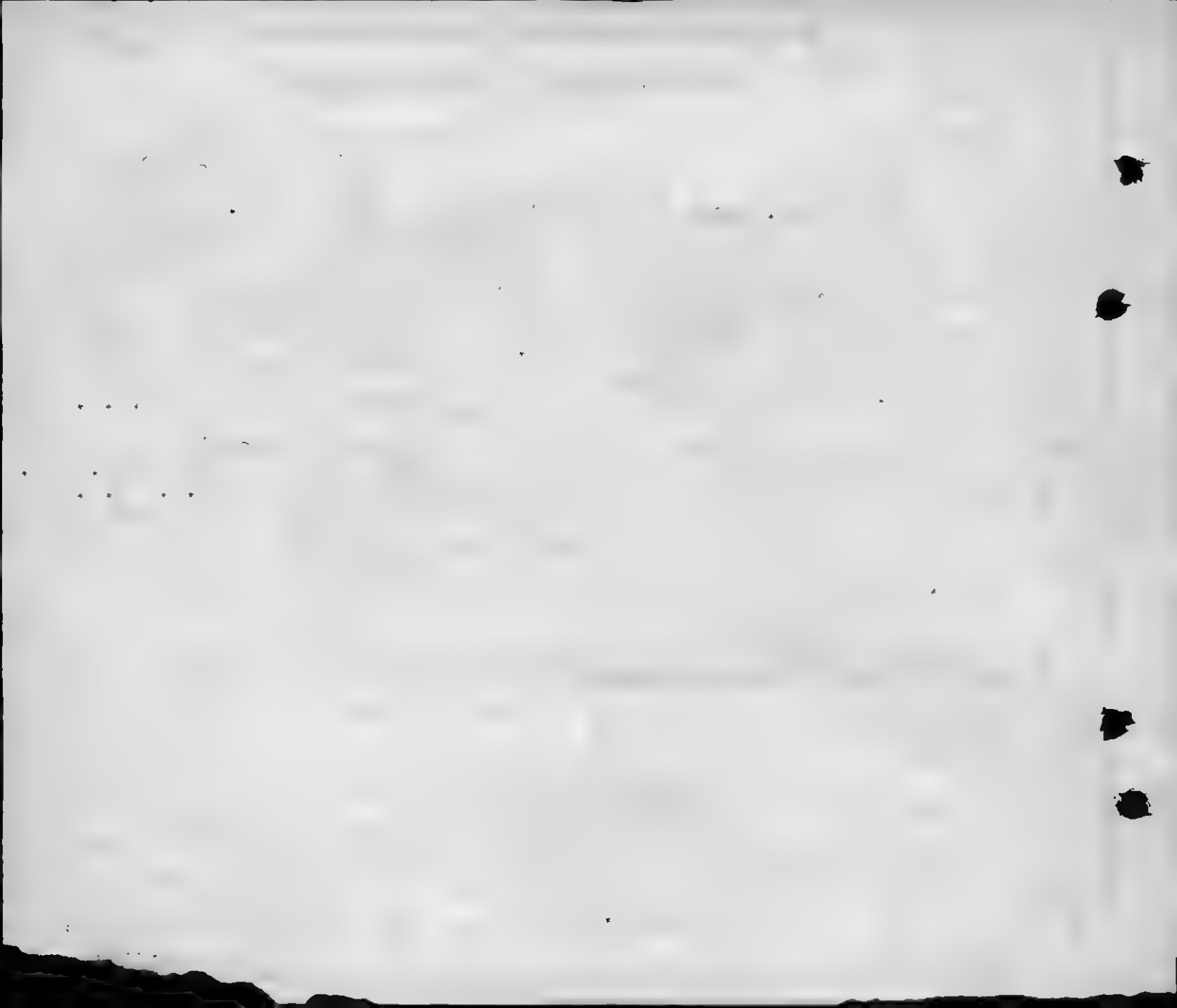
06969

6990

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <b>Montgomery</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural Mt. Airy</b> LENGTH OF STAY (in this place) <b>8 years</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Montgomery</b> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural Mt. Airy</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (if rural give location)			
3. NAME OF DECEASED (Type or Print) (First) <b>Marian</b> (Middle) <b>Groomes</b> (Last) <b>Meem</b>				4. DATE OF DEATH (Month) <b>June</b> (Day) <b>6</b> (Year) <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>Aug. 7 1864</b>	9. AGE last birthday <b>94</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. School Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hanson Groomes</b>				14. MOTHER'S MAIDEN NAME <b>Henretta Cashell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <b>No</b> (If Yes, give year or dates of service)		16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT & ADDRESS <b>Virginia Groomes 2126 Conn. Ave. N.W. D.C.</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>Anteriosclerotic cardiovascular disease</b>				INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>11</b> , 19 <b>58</b> , to <b>6</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3</b> , 19 <b>58</b> , and that death occurred at <b>.....</b> M., from the causes and on the date stated above.							
SIGNATURE <b>Arthur S. Kneass</b>				ADDRESS (Street, city, town, state) <b>DAMASCUS MD 5/25/59</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>June 9 59</b>		NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>		LOCATION (City, town, or county) (State) <b>Olney Md.</b>	
24. REC'D BY REGISTRAR DATE <b>JUN 11 '59</b>		REGISTRAR'S SIGNATURE <b>Arthur S. Kneass</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Barber Laytonsville</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6991

## CERTIFICATE OF DEATH

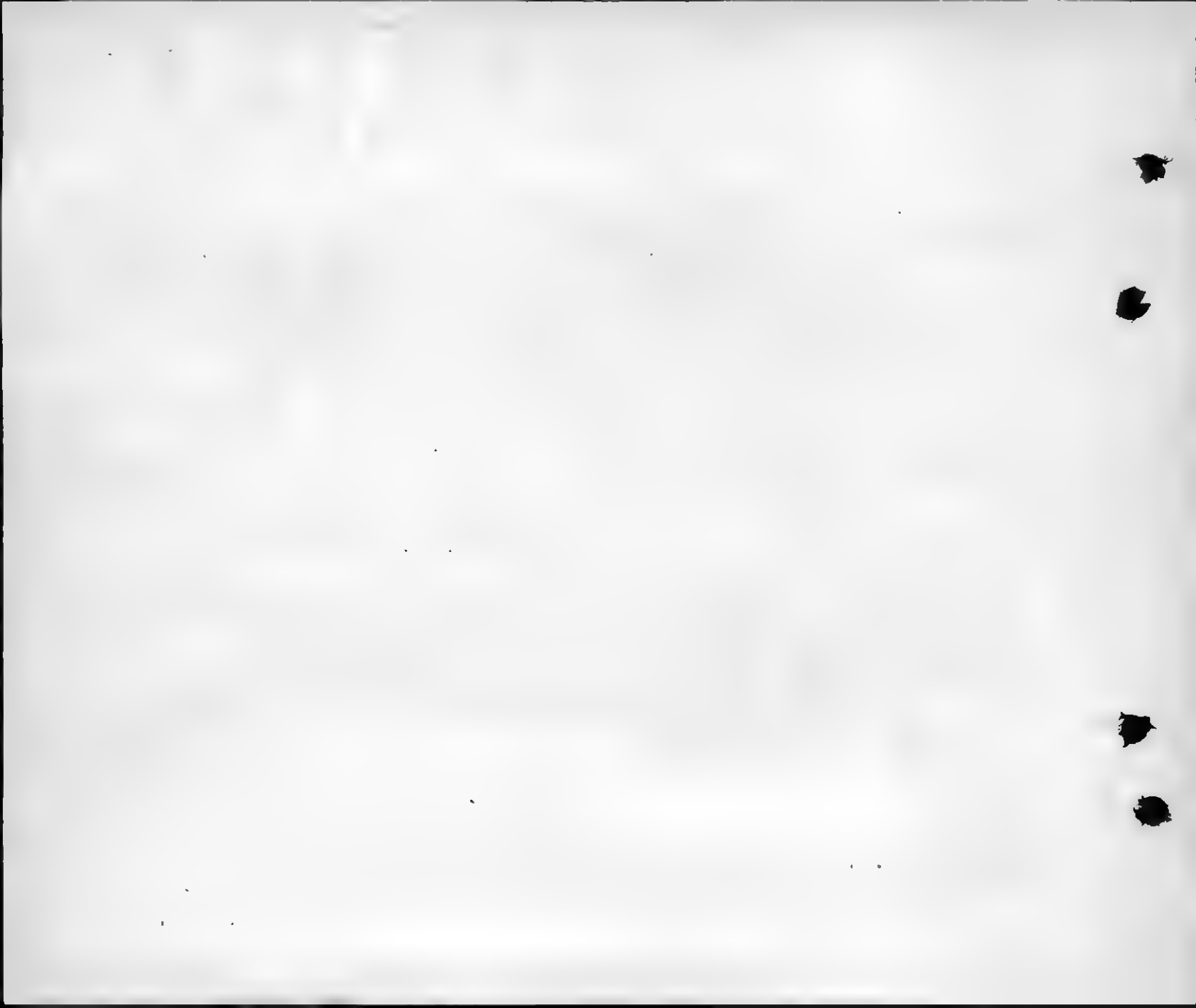
06970

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>5 mo</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brooke Grove Foundation</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> <u>47X-3</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>3727 Jocelyn St., N.W.</u>	
3. NAME OF DECEASED (Type or print) <u>ella</u> First <u>Jane</u> Middle <u>Meyer</u> Last		4. DATE OF DEATH <u>June 14, 1959</u> Month <u>June</u> Day <u>14</u> Year <u>19</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Radnor, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Mather</u>		14. MOTHER'S MAIDEN NAME <u>Hannah Barr</u> <u>Boise Idaho</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>(Son) T.F. Meyer - 906 Marshall St. Boise - Idaho</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocarditis</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>green</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-14-</u> , 1959, to <u>6-14-</u> , 1959, that I last saw the deceased alive on <u>6-14-</u> , 1959, and that death occurred at <u>3:40 P.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>6/14/59</u>			
ACTUAL SIGNATURE <u>J.W. Bird</u>		M.D. <u>Sandy Spring</u>	
PHYSICIAN'S NAME (Type) <u>J.W. Bird</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>6/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>THE S.H. HINES Co.</u> ADDRESS <u>2901-14th St N.W. D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



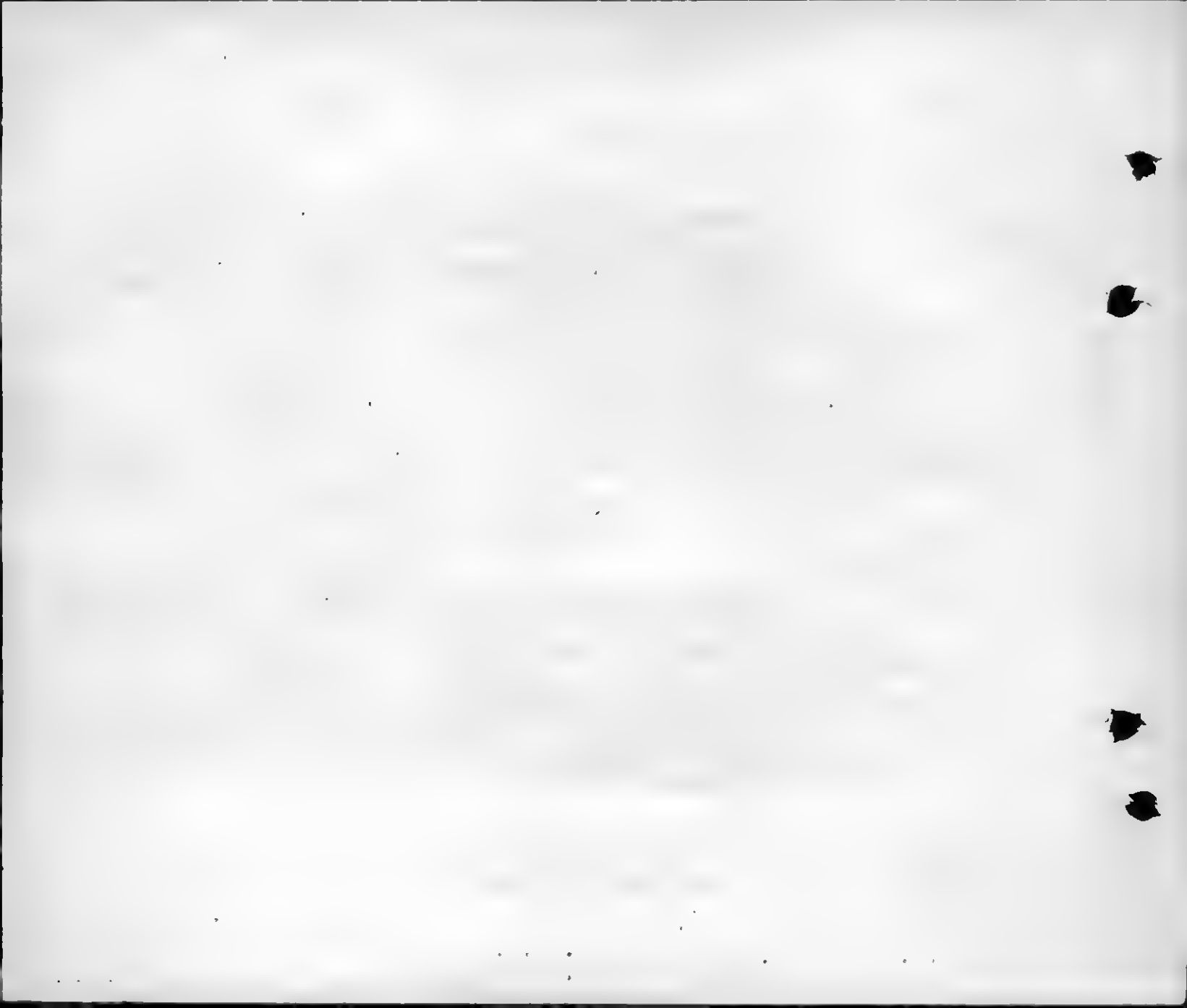
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 MD 6992 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

06971

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chillum</b> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Kensington Gardens Nursing Home</b>		d. STREET ADDRESS <b>629 Sheridan St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Susie</b> Middle <b>E.</b> Last <b>Meyers</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/14/69</b>
9. AGE (In years last birthday) <b>90</b> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William H. Starr</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Doxen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO (b) <b>3 Senility (ages approx 90)</b> DUE TO (c) <b>4 Partially Blind (50%)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>yr</b> <b>yr</b> <b>yr</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/2/59</b> , 19, to <b>6/10/59</b> , 19, that I last saw the deceased alive on <b>6/9/59</b> , 19, and that death occurred on <b>6/10/59</b> , 19, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>SAM ALLEN, M.D.</b>		ADDRESS (Street, city or town, state) <b>Kensington, Md.</b>	
PHYSICIAN'S NAME (Type) <b>SAM ALLEN, M.D.</b>		DATE SIGNED <b>6/10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>6/13/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		24. REC'D BY REGISTRAR <b>JUN 12 1959</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>		24c. ADDRESS <b>2901 14th St. N.W. Washington 9, D.C.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6993

CERTIFICATE OF DEATH

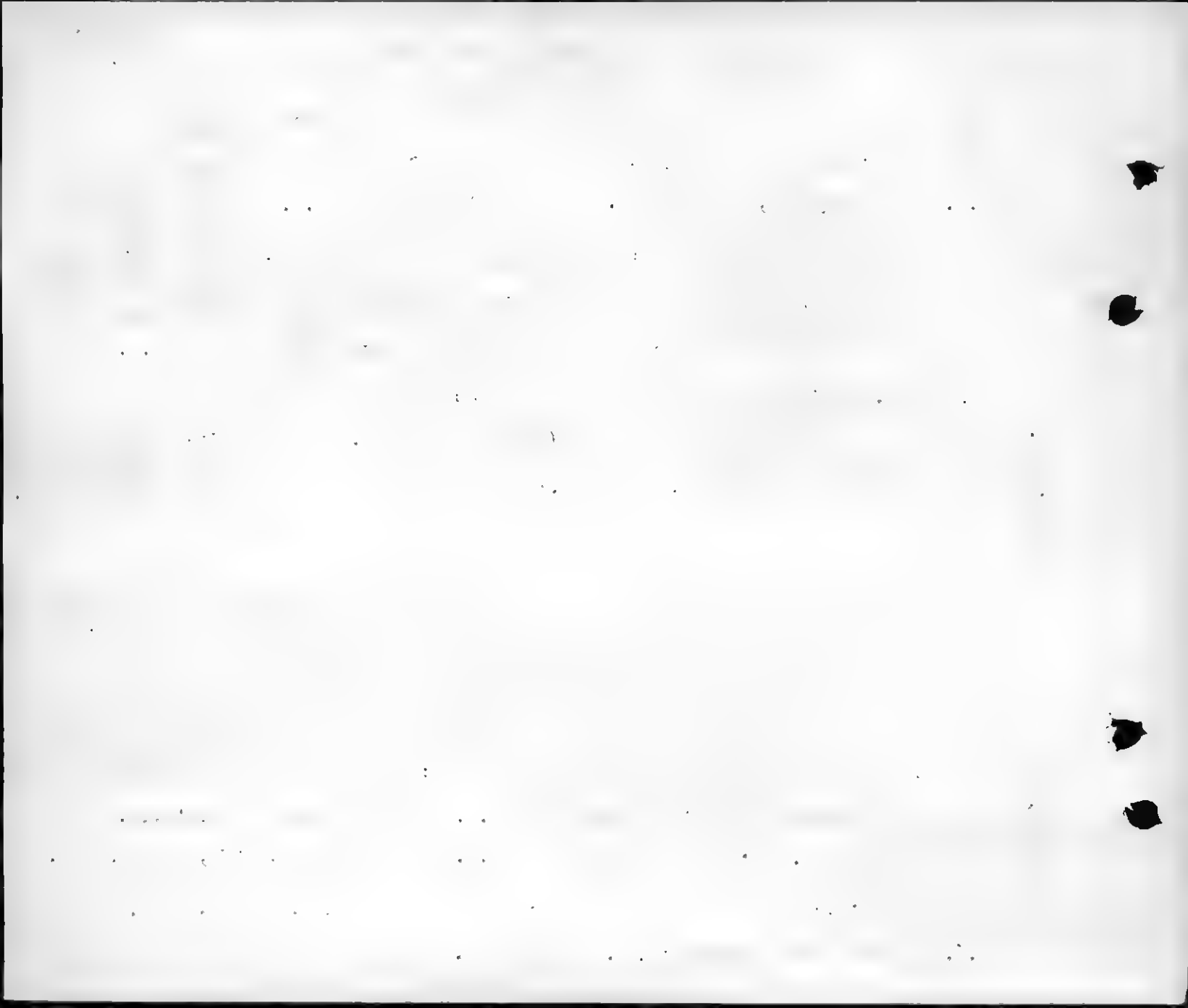
06972

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>15 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>District of Columbia</b>		b. COUNTY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>3320 14th Place S.E.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Scott</b>		Middle <b>Alan</b>		Last <b>MICHEALS</b>		4. DATE OF DEATH Month <b>June</b>		Day <b>12</b>		Year <b>19 59</b>					
5 SEX <b>Male</b>		6 COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7 December 1958</b>		9. AGE (In years last birthday) yrs <b>6</b> Months <b>5</b> Days <b>5</b> Hours <b>5</b> Min.		IF UNDER 1 YEAR		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Warren R. MICHEALS</b>						14. MOTHER'S MAIDEN NAME <b>Joan KAPLIN</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>INFORMANT</b>				Address <b>(Father) Warren R. MICHEALS Same as #2</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> <b>7-4-7</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congenital Heart Disease - Aortic Stenosis, Mitral Regurgitation</b> DUE TO (c) <b>6 mos</b>												INTERVAL BETWEEN ONSET AND DEATH <b>4 1/2 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>28 May</b> , 19 <b>59</b> , to <b>12 June</b> , 19 <b>59</b> that I last saw the deceased alive on <b>12 June</b> , 19 <b>59</b> , and that death occurred at <b>3:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Gerald I. Shugoll M.D. U.S. Naval Hospital, Bethesda, Md.</b>															
ACTUAL SIGNATURE <b>Gerald I. Shugoll</b>				PHYSICIAN'S NAME (Type) <b>Gerald I. SHUGOLL LT MC USN U.S. Naval Hospital, NNMC, Bethesda Md.</b>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-shipment 6-13-59</b>				22b. DATE THEREOF				22c. NAME OF CEMETERY OR CREMATORY <b>Mount Sharon</b>				22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Penn.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>R.A. Pumphrey</b>				ADDRESS <b>1537 Wisconsin Ave. Bethesda Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 16 '59</b>				24b. REGISTRAR'S SIGNATURE <b>C. J. H. H. H.</b>			

Montgomery County Medical Examiner notified.

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 6994 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07137

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within 72 hours after death. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM-3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 could be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Va</u> b. COUNTY <u>Arlington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>N. Brookmont</u>		c. LENGTH OF STAY IN 1b <u>15 min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Solimar River</u>		d. STREET ADDRESS <u>2708 N Buchanan</u>	
3. NAME OF DECEASED (Type or print) <u>Robert Burnham Milleken</u>		4. DATE OF DEATH Month <u>Jun</u> Day <u>27</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 9 1942</u>
9. AGE (in years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>18</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TEXAS-</u>	
11. BIRTHPLACE (State or foreign country) <u>TEXAS-</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>C. B. Milleken</u>		14. MOTHER'S MAIDEN NAME <u> Evelyn Mackedon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>507244100</u>	
17. INFORMANT <u>Francis Hurst</u>		Address <u>507244100 Blvd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Choking</u> (c) <u>Asphyxia</u> DUE TO cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Asphyxia</u> Interval between onset and death <u>Asphyxia</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Injured while swimming in Pot. R</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10:30 p.m.</u> <u>6-26</u> 19 <u>59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Pot. R</u>	20f. (City or town) <u>N. Brookmont</u> (County) <u>Montgomery</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Buschert</u>		DATE SIGNED <u>6-27-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. BUSCHERT</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-30-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	22d. LOCATION (City, town, or county) <u>Arlington, Va.</u> (State) <u>Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hurst</u>		24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hurst</u>

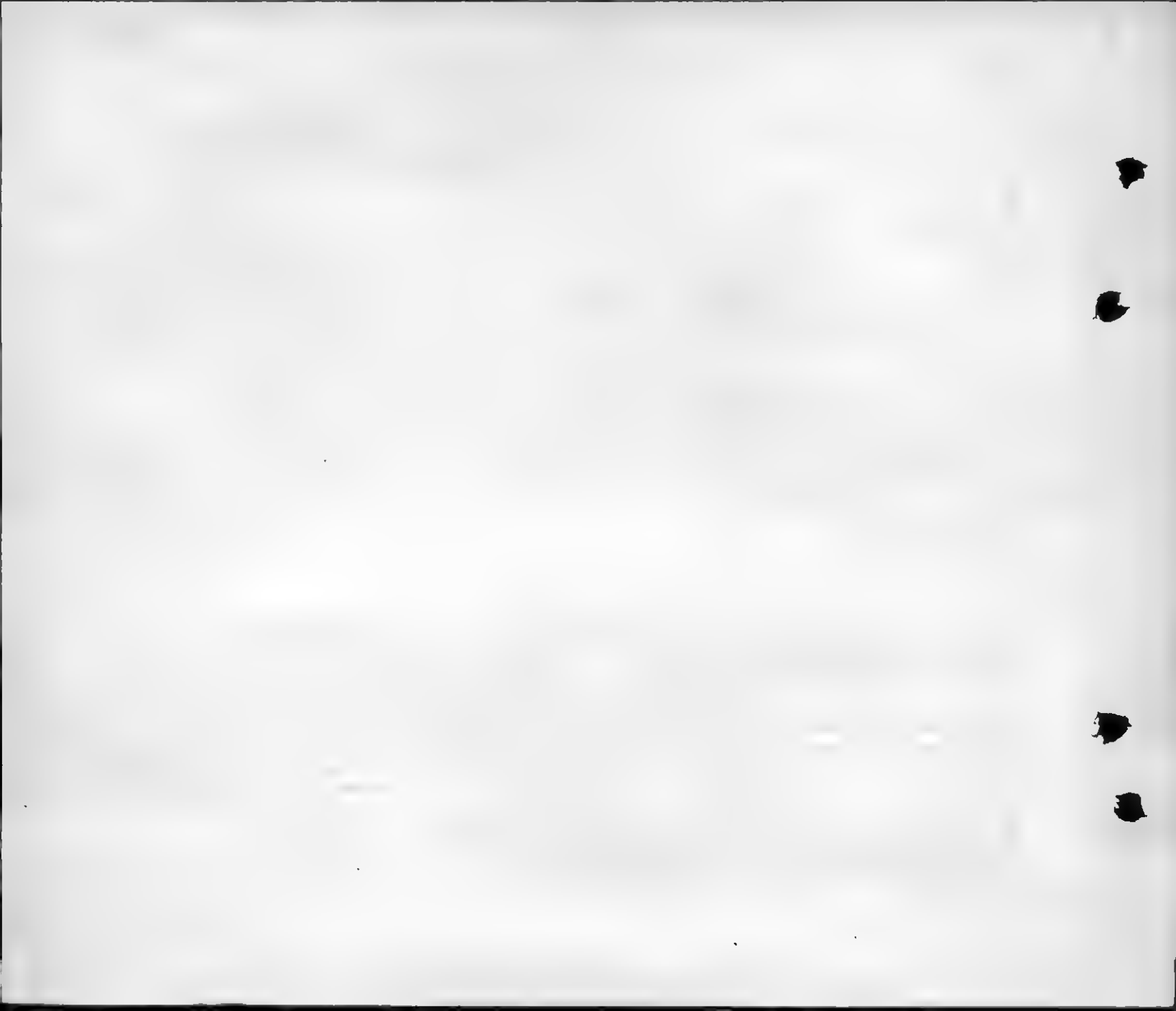


## 6884 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Infant boy</u> First <u>Miller</u> Middle Last				4. DATE OF DEATH <u>June 6 - 19 59</u> Month Day Year			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-3-59</u>	
9. AGE (In years last-birthday) yrs. <u>3</u>		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>3</u> Min <u>3</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Takoma Park-Md.</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Hiram T. Miller</u>				14. MOTHER'S MAIDEN NAME <u>Fonda T. Tamm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO		17. INFORMANT <u>Infant's chart</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Permaternity</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>3 days</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <u>6-3-1959</u> to <u>6-6-1959</u> , that I last saw the deceased alive on <u>6-6-1959</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE: <u>Russell B. Arnold</u> M.D. 8801 Colfaxville Road, <u>6-6-59</u>				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>June 7-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brighton Park</u>		22d. LOCATION (City, town, or county) (State) <u>Lee County Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walter</u> ADDRESS <u>254 Carroll St</u>				24a. REC'D BY REGISTRAR <u>D.B.</u> DATE JUN 9 '59		24b. REGISTRAR'S SIGNATURE <u>Charles S. King</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be signed by the attending physician and completed by the funeral director. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon page 1 and 2 and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



6995

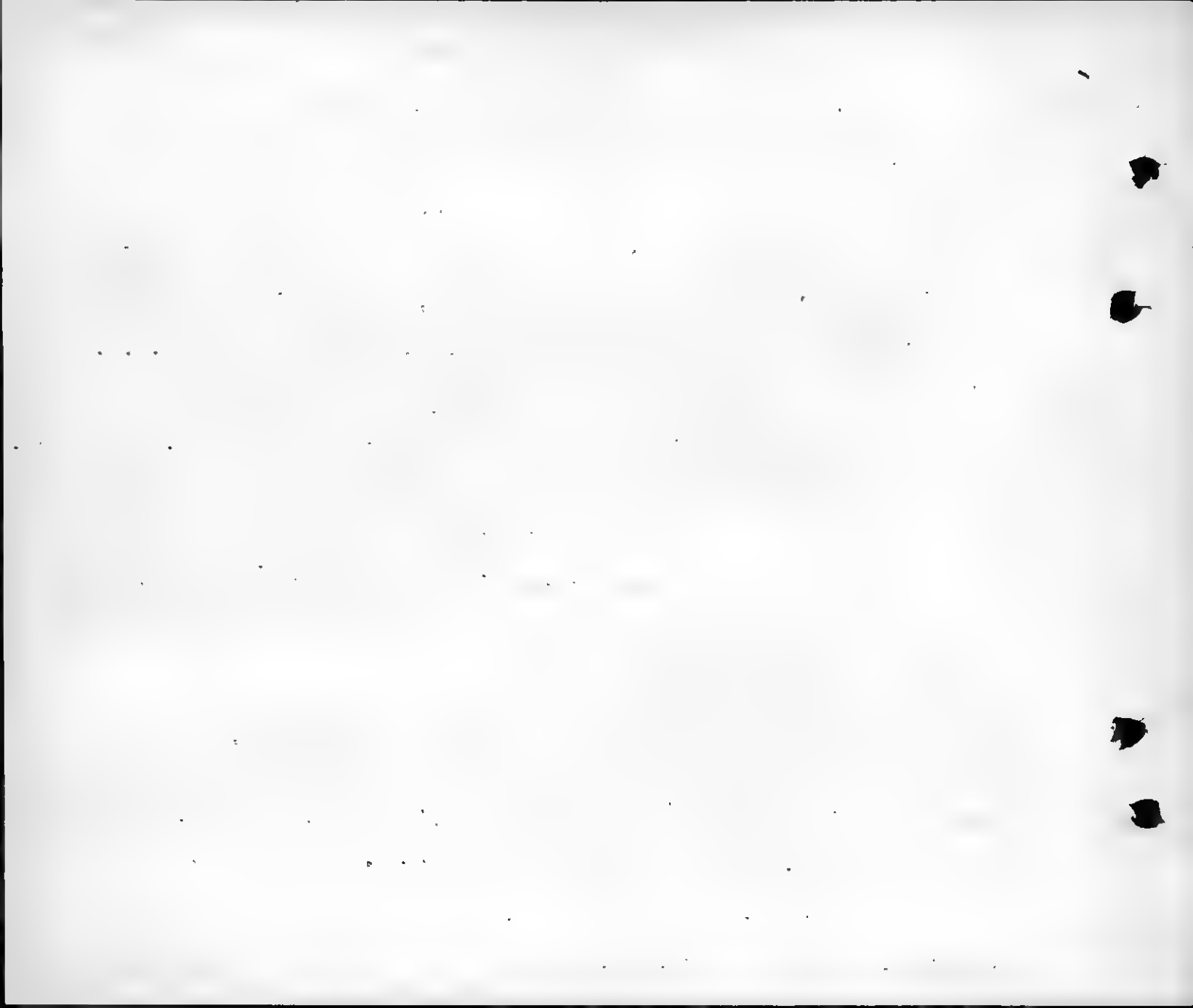
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>				d. STREET ADDRESS <b>7802 Marion Lane</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MATILDA</b>		First <b>E</b> Middle <b>MILLER</b> Last		4. DATE OF DEATH Month <b>June</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 14, 1887</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>8</b> Hours <b></b> Min <b></b>		IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min <b></b>			
10a. U.S.A. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Wise, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Clark Vaughan</b>				14. MOTHER'S MAIDEN NAME <b>Susan Elizabeth Skeen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Son</b> Address			
				<b>Emory H Miller-2807 Byron St. Silver Sp.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Coronary Occlusion</b> DUE TO (c) <b>Hypertensive Cardiac Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>2 hr.</b> <b>10 hr.</b>							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>13 June</b> , 19 <b>59</b> , to <b>22 June</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>22 June</b> , 19 <b>59</b> , and that death occurred at <b>6:35 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>7936 Georgetown Rd.</b> DATE SIGNED ACTUAL SIGNATURE <b>John B. Ball</b> M.D. <b>Bethesda, Md</b> PHYSICIAN'S NAME (Type) <b>John G. Ball</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6/24/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey</b>				ADDRESS <b>Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 24 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

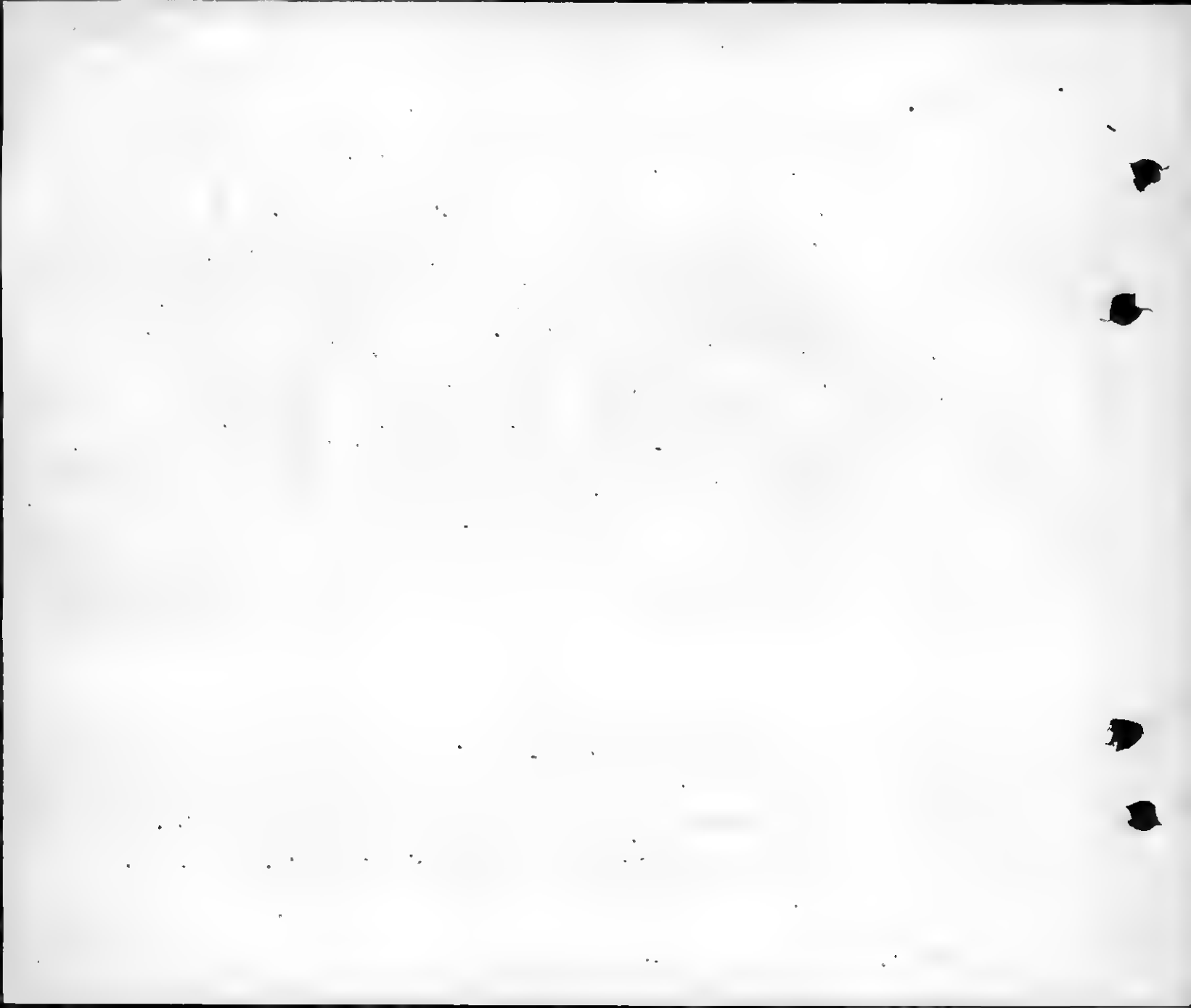


6996

## CERTIFICATE OF DEATH

Reg. Dist. No.

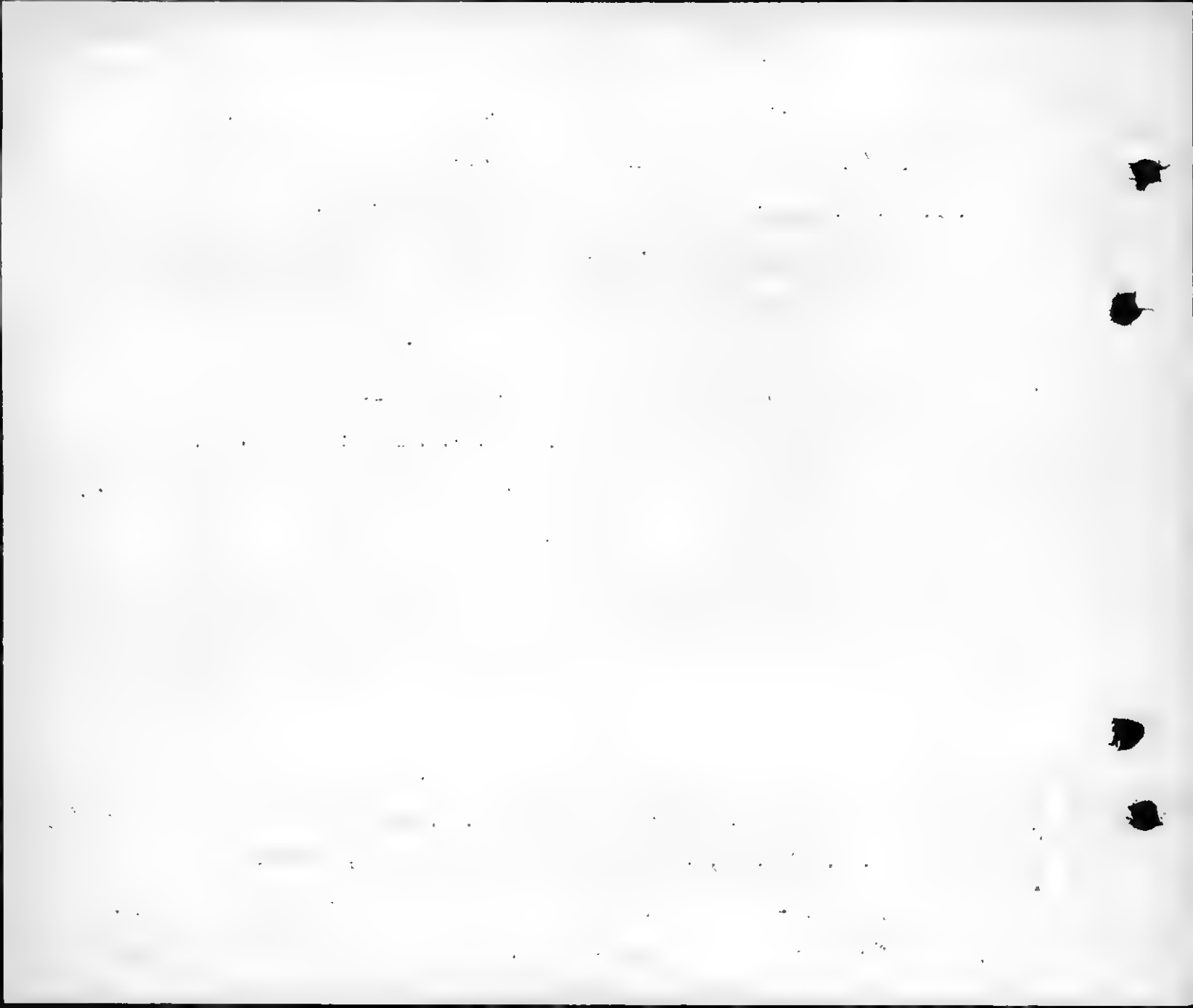
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Geo.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SUBURBAN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WARD</u> Middle <u>MILLER</u> Last <u>MILLER</u>		4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18 1877</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>8</u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>L.C. Smith Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Columbia, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel MILLER</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>074-05-9382A</u>	
17. INFORMANT <u>Ward Miller Jr.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS, Rt. Middle Lobe</u> 472 X DUE TO <u>Staphylococcus aureus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 16, 1959</u> , to <u>June 26, 1959</u> , that I last saw the deceased alive on <u>June 24, 1959</u> , and that death occurred at <u>1:35 P.M.</u> from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Delwitt E. DeLaughter, M.D.</u>		ADDRESS (Street, city or town, state) <u>8025 ABERDEEN Rd Bethesda Md.</u> DATE SIGNED <u>6/26/59</u>	
PHYSICIAN'S NAME (Type) <u>DELWITT E. DELAUGHTER</u>		8025 Aberdeen Rd. Beth. Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u>		22b. DATE THEREOF <u>7/1/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Iliom Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Iliom, New York</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	





MEDICAL CERTIFICATION

VS A15 (4)  
15M 9/5B



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the paper pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6998

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>District of Columbia</i> b. COUNTY <i>Washington</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Beltsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Wheaton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Suburban</i>		d. STREET ADDRESS <i>2626 - Florida Rd NE</i>	
3. NAME OF DECEASED (Type or print) First <i>Keith</i> Middle <i>K.</i> Last <i>Miss</i>		4. DATE OF DEATH Month <i>June</i> Day <i>20</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Unknown</i> Approx. <i>1867</i>
9. AGE (In years last birthday) <i>86</i> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles King</i>		14. MOTHER'S MAIDEN NAME <i>Elizabeth Jones</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Donald Nelson</i> Address <i>10620 Bayview Ave, Silver Spring, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Stroke</i> (b) <i>ruptured cerebral arterial aneurysm</i> (c) <i>congenital weakness of vascular wall</i> DUE TO <i>brain aneurysm</i> DUE TO <i>congenital weakness of vascular wall</i> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Brain aneurysm</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>18 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 1</i> , 19 <i>59</i> , to <i>June 20</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>June 20</i> , 19 <i>59</i> , and that death occurred at <i>7</i> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald Nelson</i> M.D.		ADDRESS (Street, city or town, state) <i>10620 Bayview Ave, Silver Spring, Md.</i> DATE SIGNED <i>June 25 '59</i>	
PHYSICIAN'S NAME (Type) <i>Donald Nelson</i>			
22a. BURIAL (CREMATION, REMOVAL) (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>6-23-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Swettland Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>DEAL FUNERAL Home</i> ADDRESS <i>4812 6th Ave</i>		24a. REC'D BY REGISTRAR <i>June 25 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



6999

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>6 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL, INC.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>HOWARD</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAYTON</b> d. STREET ADDRESS <b>156...</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>GRACE</b> Last <b>MULLINIX</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>1</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/12/88</b>
9. AGE (In years last birthday) <b>71</b> yrs		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>days</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>WILLIAM MUSGROVE</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE CROOKS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>York</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address <b>OLNEY, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Uremia</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Nephrosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis with coronary sclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>6 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>July 1, 1946</b>	
20f. (City or town) <b>June 1, 1959</b>		(County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1946</b> to <b>June 1, 1959</b> , that I last saw the deceased alive on <b>June 1, 1959</b> , and that death occurred at <b>1:17 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Charles S. Whitaker, M.D.</b>		DATE SIGNED <b>6-1-59</b>	
PHYSICIAN'S NAME (Type) <b>C. S. WHITAKER, M. D.</b>		<b>CLARKSVILLE, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-4-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mt View</b>	22d. LOCATION (City, town, or county) (State) <b>Alpha, Howard Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Wright, Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 3 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



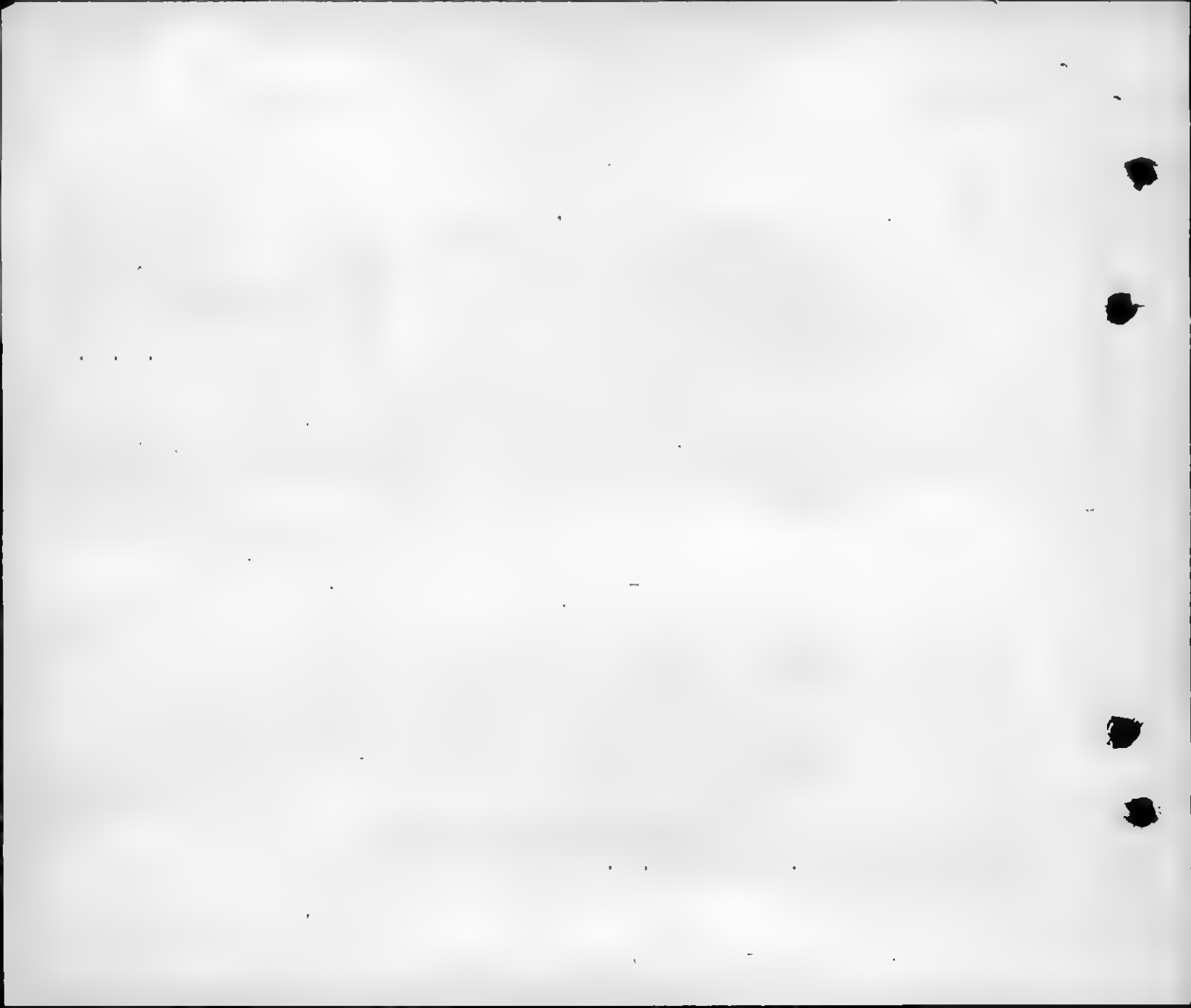
7000

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>58 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>West Hollywood</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hollywood</b> d. STREET ADDRESS <b>404 South West 62nd Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph Lavell Nelson</b>				4. DATE OF DEATH Month Day Year <b>June 9, 1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1934</b>	
9. AGE (In years last birthday) <b>25</b> yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
13. FATHER'S NAME <b>Grady Nelson</b>				14. MOTHER'S MAIDEN NAME <b>Ira Graben</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>416-42-7905</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>759.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Congenital Heart Disease - Total Anomaly of Pulmonary Veins</b> DUE TO (c) <b>Post-Operative adrenal hyperplasia</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>June 9, 1959</b>				20g. (County) <b>June 9, 1959</b>			
20h. (State) <b>June 9, 1959</b>				20i. (City or town) <b>June 9, 1959</b>			
21. I certify that I attended the deceased from <b>April 12, 1959</b> , to <b>June 9, 1959</b> , that I last saw the deceased alive on <b>June 9, 1959</b> , and that death occurred at <b>11:50 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Leon I. Goldberg</b> M.D.				ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Leon I. Goldberg, M. D.</b>				DATE SIGNED <b>6/10/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial-Transit</b>		<b>6/11/59</b>		<b>Jasper, Alabama</b>		<b>Jasper, Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 15 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kiser</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate and taken to the burial-transit permit. Then please remove carbon copy of the certificate and file it in the registrar's office. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6885 CERTIFICATE OF DEATH

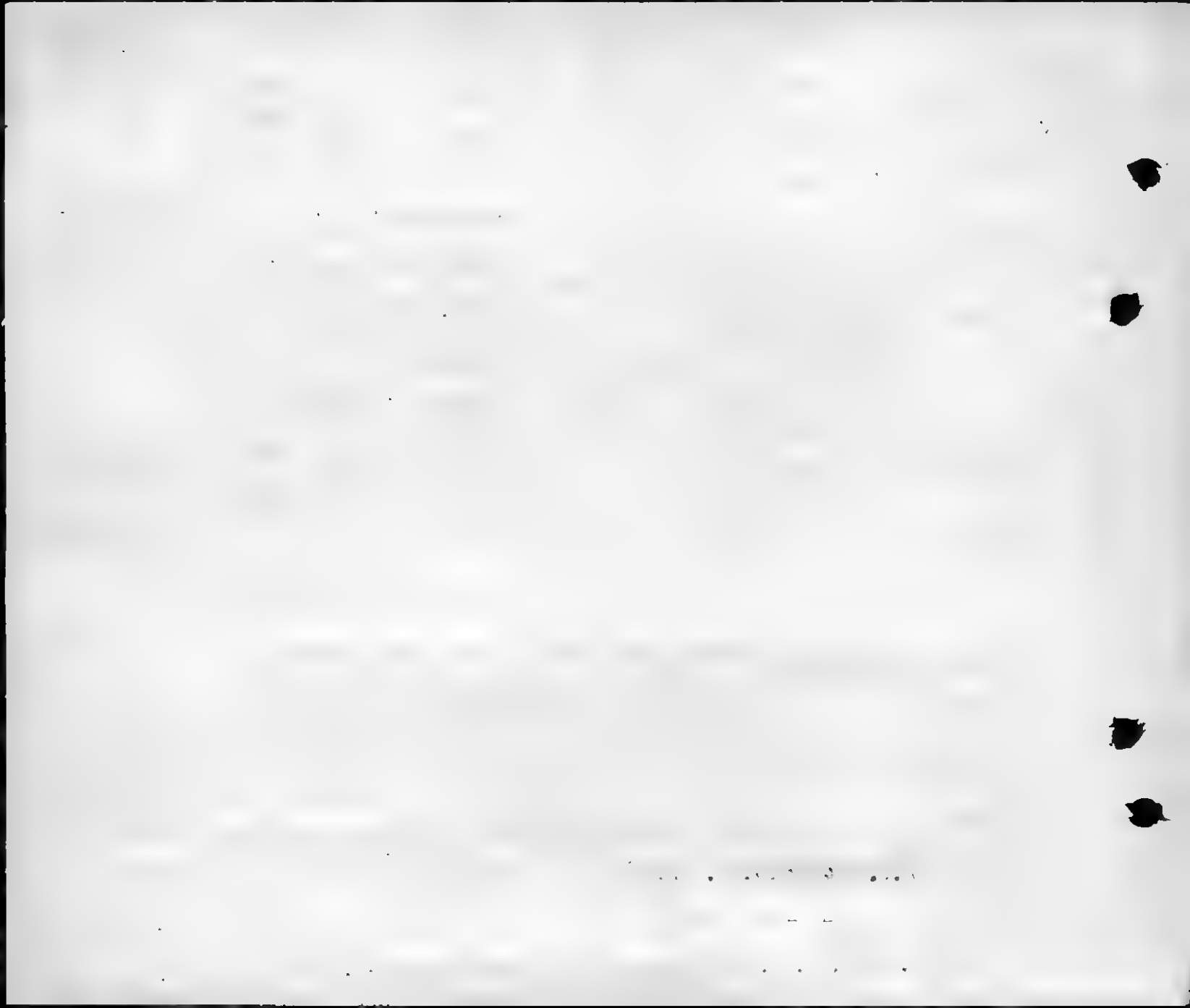
08154

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park,</b> c. LENGTH OF STAY IN 1b <b>Silver Spring,</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanitarium and Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>410 Bonifant Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Newcomb</b>		4. DATE OF DEATH Month <b>June</b> Day <b>28</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1959</b>
9. AGE (In years last birthday) yrs. <b>18</b> Months <b>18</b> Days <b>18</b> Min		10. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>America</b>		13. FATHER'S NAME <b>James Edward Newcomb</b>	
14. MOTHER'S MAIDEN NAME <b>Margaret Gayle Renfro</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>father</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity - 27 1/2 weeks gestation</b> <b>716x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cause unknown</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-27</b> , 19 <b>59</b> , to <b>6-28-59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6-28</b> , 19 <b>59</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Emma Hughes</b>		ADDRESS (Street, city or town, state) <b>Washington Sanitarium &amp; Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Emma Hughes, M.D.</b>		LOCATION (City, town, or county) (State) <b>Takoma Park, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>7-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Sanitarium and Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Takoma Park, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Hare, M. D.</b>		ADDRESS <b>Washington Sanitarium and Hospital</b>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Finner</b>	

TO HOSPITAL OR FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or funeral home. After the certificate has been signed by the attending physician and completed, page 3 should be detached from the certificate and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JUL 30 '59



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 6 could be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

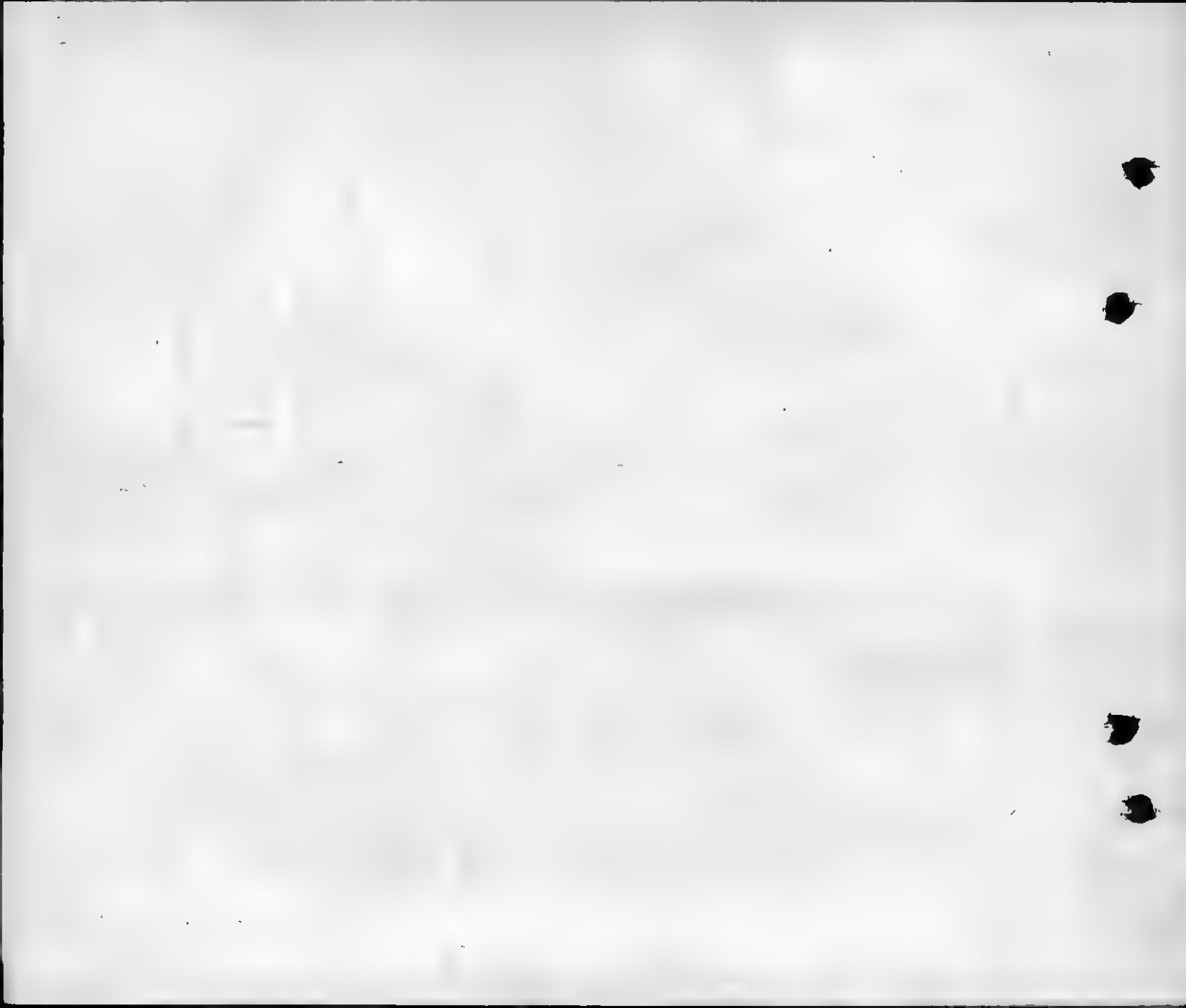
7001

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06981

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Ind</u> b. COUNTY <u>Montg</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		d. STREET ADDRESS <u>10417 Montrose Ave. - Apt 102</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10417 Montrose Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Frank Dwing</u>		4. DATE OF DEATH Month <u>June</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 25 1921</u>
9. AGE (In years last birthday) <u>37</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chemist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AEC</u>	
11. BIRTHPLACE (State or foreign country) <u>Col</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>Claud Dwing</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Zeltman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO <u>—</u>	
17. INFORMANT <u>Geraldine Dwing</u>		Address <u>Stun 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, Subendocardial</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Coronary Arteriosclerosis</u> (c) <u>Coronary Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Hours</u> <u>Hours</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Boschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Boschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>June 15 1959</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		22b. DATE THEREOF <u>June 18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State) <u>San Francisco Cal</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest A. Adams</u>		ADDRESS <u>4174 S. Wash</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
DATE <u>JUN 18 '59</u>			



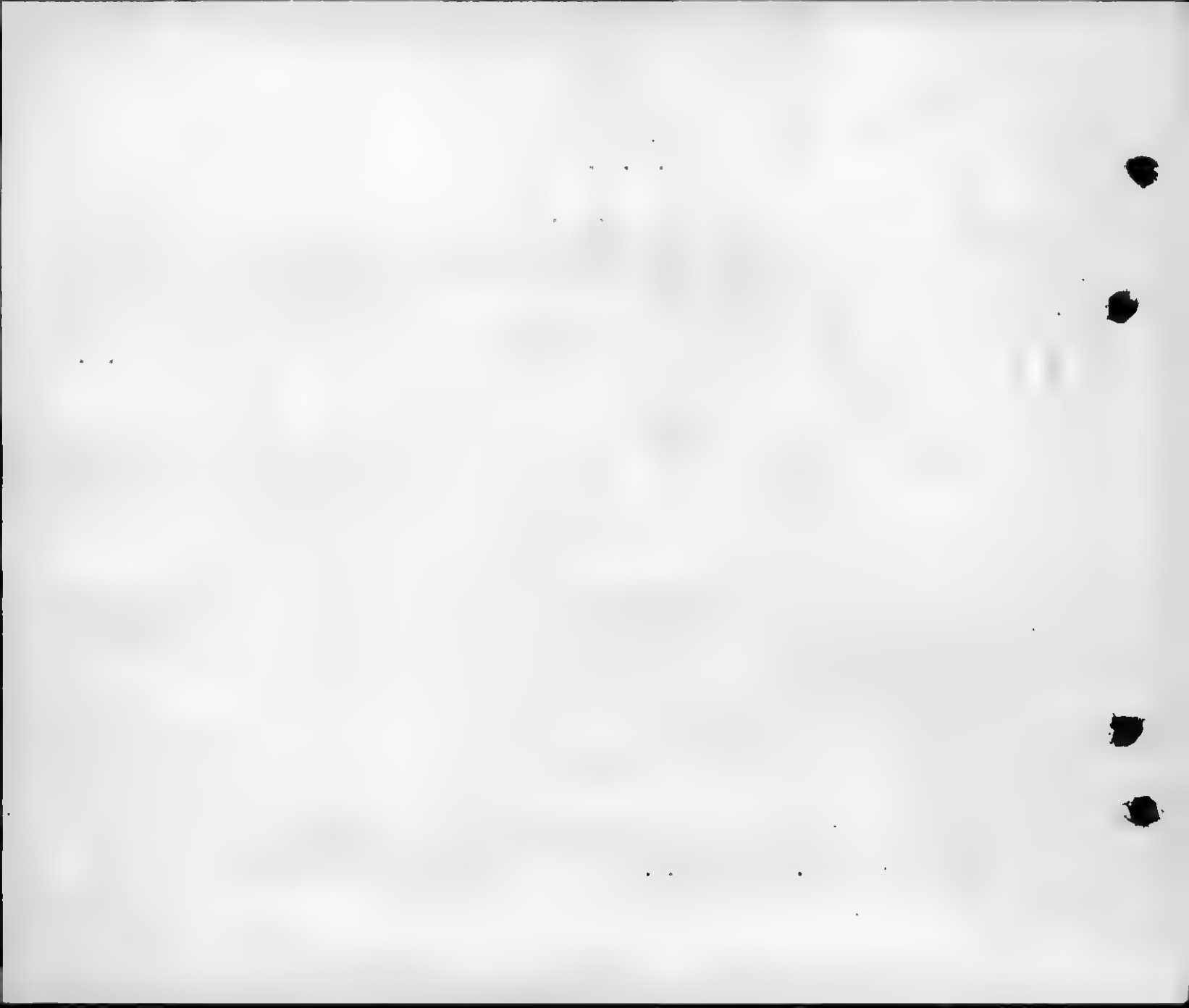
7002

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>D. O. A.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Loudoun</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sterling</u> d. STREET ADDRESS <u>Route 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Geneva Elizabeth Payne</u>		4. DATE OF DEATH Month Day Year <u>June 28, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1926</u>
9. AGE (In years last birthday) <u>33</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Hawkins</u>		14. MOTHER'S MAIDEN NAME <u>Olivia Gantt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-48-7838</u>	
17. INFORMANT <u>The Medical Record</u>		Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>14 Partial obstruction of airway by blood</u> DUE TO (b) <u>Massive hemorrhage at site of Q tonsil</u> DUE TO (c) <u>Recurrent carcinoma Q tonsil</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>minutes</u> <u>4 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 15, 1959</u> to <u>June 19, 1959</u> , that I last saw the deceased alive on <u>June 19, 1959</u> , and that death occurred at <u>3:25 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <u>The Clinical Center</u> <u>6/29/59</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>			
ACTUAL SIGNATURE <u>Howard M. Radwin, M.D.</u>		PHYSICIAN'S NAME (Type) <u>Howard M. Radwin, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>7/1/1959</u>		22b. DATE THEREOF <u>7/1/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Paul Methodist Church</u>		22d. LOCATION (City, town, or county) (State) <u>Arxon Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert G. Mason</u> <u>J. O. E. THOMAS</u>		ADDRESS <u>2500 Nichols Ave S.E. Wash. D.C.</u>	
24a. REC'D BY REGISTRAR <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. H. H. H.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. The nature of death This patient had been followed in our Outpatient Clinic. Therefore, The Medical was not unexpected considering the primary diagnosis. Examiner was not notified.



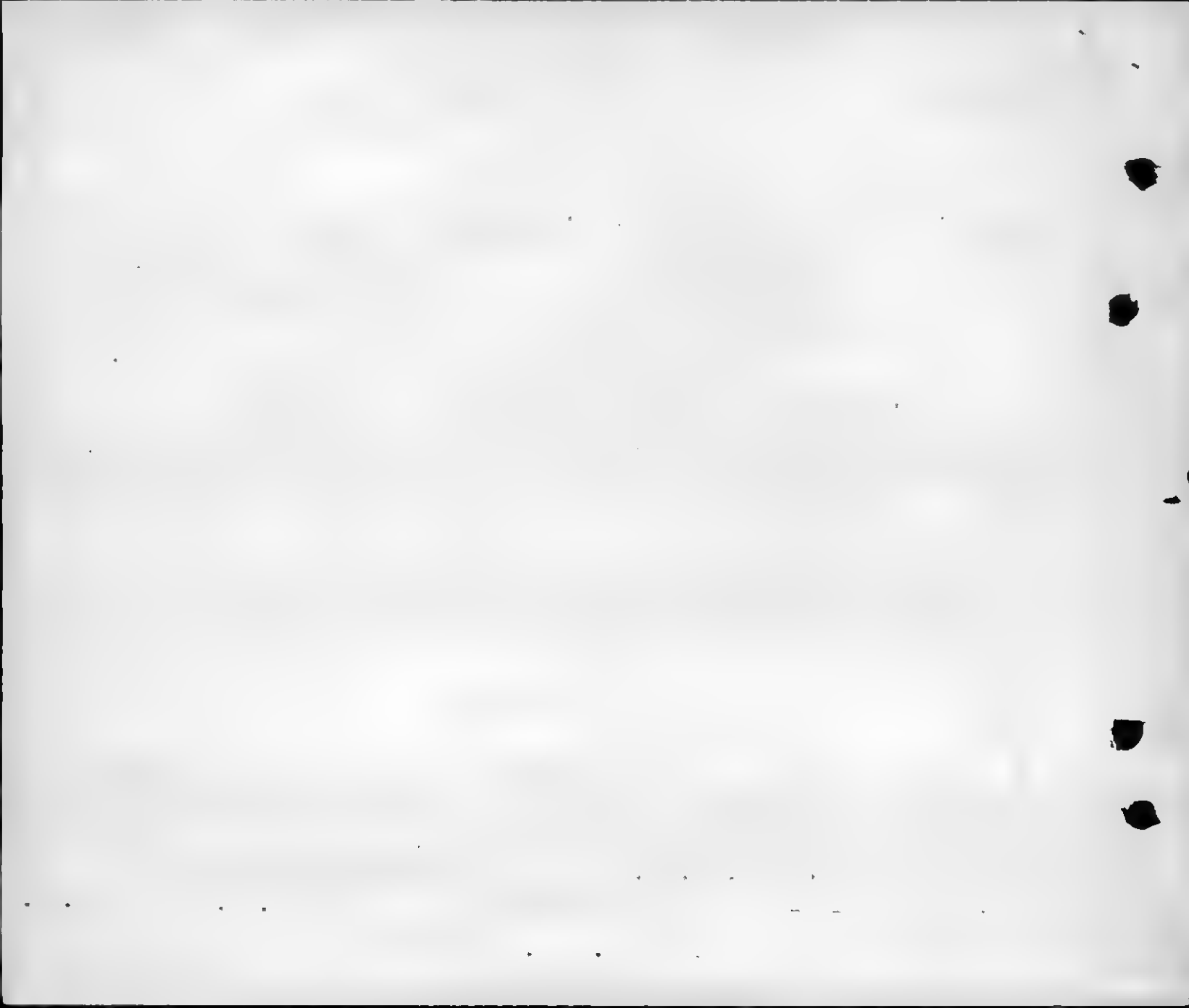
7003  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>36 days</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>			2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Elkview</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route 3, Box 227</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Arthur</u> Last <u>Phillips</u>			4. DATE OF DEATH Month <u>June</u> Day <u>26</u> Year <u>1959</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 24, 1922</u>	9. AGE (In years last birthday) yrs. <u>37</u>	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>		11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>	
13. FATHER'S NAME <u>Arthur B. Phillips</u>			14. MOTHER'S MAIDEN NAME <u>Dollie Shawver</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO <u>234-20-5166</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>UREMIA</u> DUE TO <u>MALIGNANT ARTERIOLE NEPHROSCLEROSIS</u> (c) INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>months</u> <u>months</u>					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) <u>  </u>		20g. (County) <u>  </u>		20h. (State) <u>  </u>	
21. I certify that I attended the deceased from <u>May 21</u> , 19 <u>59</u> , to <u>June 26</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 26</u> , 19 <u>59</u> , and that death occurred at <u>6:20 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>John A. Oates, Jr.</u>		M.D. <u>John A. Oates, Jr., M.D.</u>		ADDRESS (Street, city or town, state) <u>The Clinical Center</u> <u>National Institutes of Health</u> <u>Bethesda 14, Maryland</u>	
DATE SIGNED <u>6/27/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-29-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Morris Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Elkview W. Va.</u>		22e. (State) <u>Kanawha W. Va.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Humphrey</u>			ADDRESS <u>7557 Wisc. Ave. Bethesda Md</u>		
24. RECEIVED BY REGISTRAR DATE <u>JUL 2 '59</u>			24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician and completed by the attending physician and completed by the attending physician. Pages 1 and 2 should be filed with the funeral director. After the death certificate has been signed by the attending physician and completed by the attending physician, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

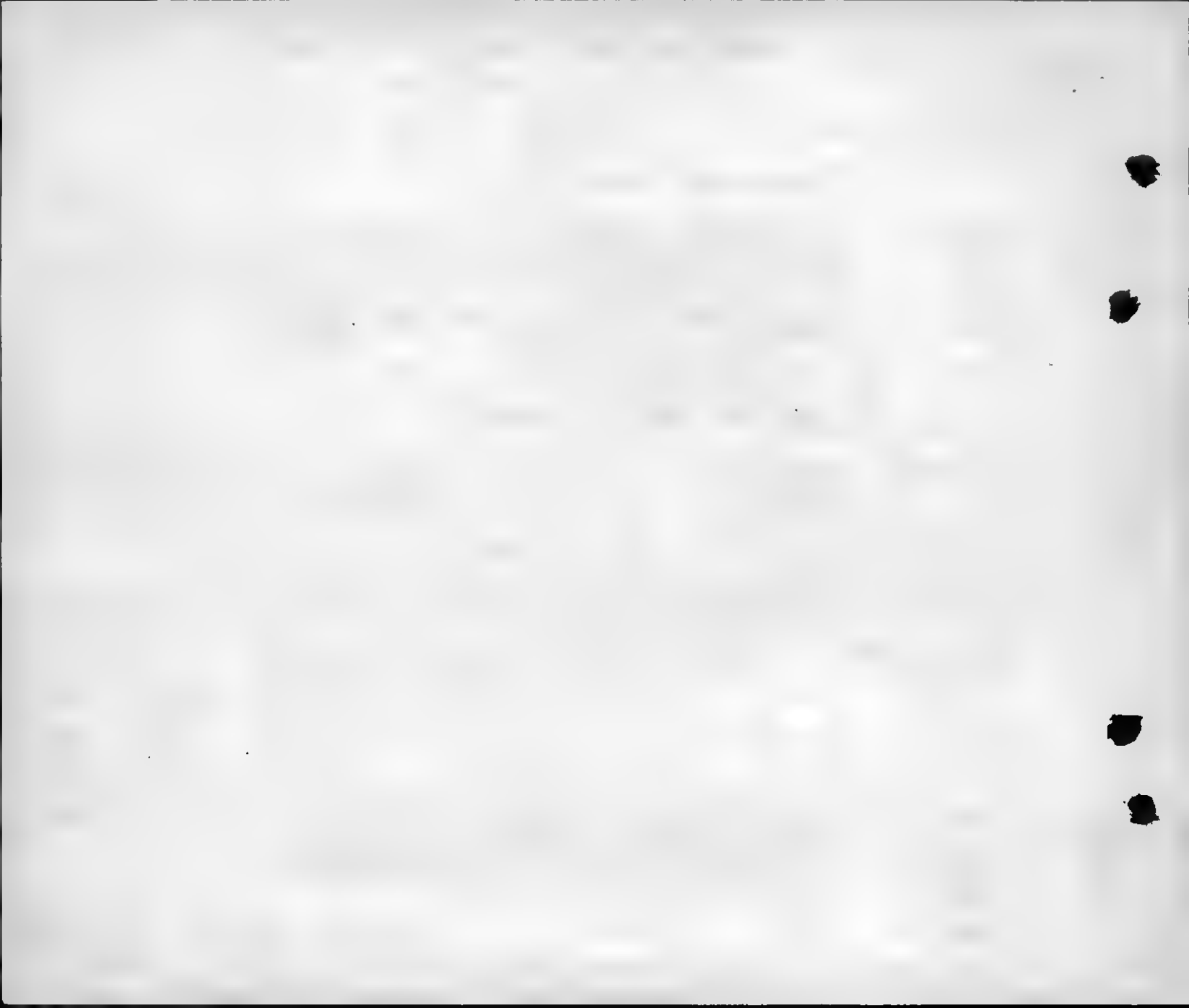
VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
7004 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06984

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>		c. LENGTH OF STAY IN TB <u>5 min</u> X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boyd</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Black Hill Rd.</u>		d. STREET ADDRESS <u>Black Hill Rd.</u> IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Bryan Phillips Jr</u> First Middle Last		4. DATE OF DEATH <u>June 27 1959</u> Month Day Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 3 - 1943</u> 15 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farm</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wm B. Phillips Sr</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Aholt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>none</u>	
17. INFORMANT <u>Harry Aholt - Son</u> Address <u>2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Thoracic hemorrhage</u> DUE TO <u>Crushed chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Crushed chest</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Driver of tractor while upset</u>	
20c. TIME OF INJURY Month, Day, Year <u>2:55 p.m. 6-27-59</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>road</u>		20f. (City or town) <u>Boyd</u> (County) <u>Montgomery</u> (State) <u>md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Brachant</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Brachant</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/29/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>		22d. LOCATION (City, town, or county) <u>Leesburg Va</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Hilton</u>		24a. REC'D BY REGISTRAR <u>June 30 '59</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14 Film 6244 7-2-59 et

7005

## CERTIFICATE OF DEATH

Reg. Dist. No.

06985

1. PLACE OF DEATH, a. COUNTY <u>Montgomery Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>6 wks.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Congressional Manor Inn</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Evarist Popper</u>				4. DATE OF DEATH Month Day Year <u>June 17 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 25 1883</u>	9. AGE (In years (last birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attorney</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Attorney</u>		11. BIRTHPLACE (State or foreign country) <u>Vienna</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Joseph Popper</u>				14. MOTHER'S MAIDEN NAME <u>Sophia Pick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-30-9796</u>		17. INFORMANT Address <u>R.C. Pollock, 4831-36 St. N.W., D.C.</u>			
18. CAUSE OF DEATH [Enter only one cause per line, or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of sigmoid colon, lung metastasis.</u> DUE TO (b) <u>metastasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>metastasis.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>May 54</u> to <u>June 17 1959</u> , that I last saw the deceased alive on <u>June 16 1959</u> , and that death occurred at <u>4831-36 St. N.W.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Rudnai</u> M.D.				ADDRESS (Street, city or town, state) <u>5120 MacArthur Blvd Wash, D.C.</u>			
PHYSICIAN'S NAME (Type) <u>ANDREW E. RUDNAI</u>				DATE SIGNED <u>6/17/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Switzland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Smith</u>				ADDRESS <u>1700 Pennsylvania Ave</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Andrew S. King</u>							



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7006

## CERTIFICATE OF DEATH

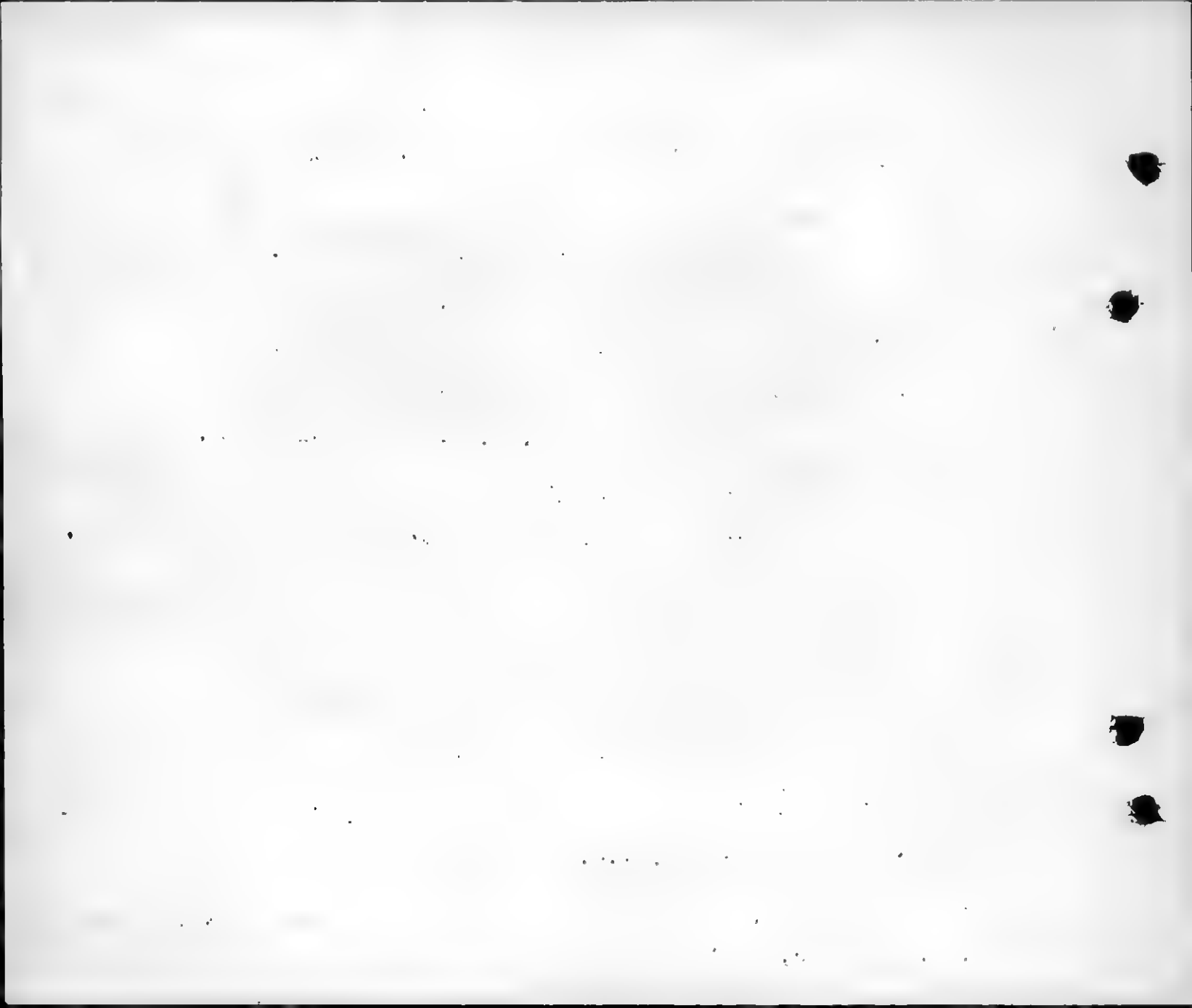
06986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hyattstown</b>		c. LENGTH OF STAY IN lb <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ROSEMARY</b> Middle <b>ELIZABETH</b> Last <b>PRICE</b>		4. DATE OF DEATH Month <b>June</b> Day <b>20</b> , Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1880</b>
9. AGE (In years last birthday) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min <b>79</b>	11. IF UNDER 24 HRS Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick County</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Tabler</b>		14. MOTHER'S MAIDEN NAME <b>Emeline Leather</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr. G. Carve Price-Same as Item #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Gen Arteriosclerotic-Hypertensive Disease</b> DUE TO <b>5 years</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>15 min (Five)</b> <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 19 59</b> to <b>30 June 19 59</b> , that I last saw the deceased alive on <b>20 June 19 59</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Barnesville, Md</b> DATE SIGNED <b>20 June 59</b> ACTUAL SIGNATURE <b>Gordon M. Smith</b> M.D. PHYSICIAN'S NAME (Type) <b>Gordon M. Smith, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 23, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattstown, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. L. Burdette, Hyattstown, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Calvin S. Farris</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Tlien please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 6886 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Prince George</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hyattsville</i>	
c. LENGTH OF STAY IN 1b <i>8 days</i>		d. STREET ADDRESS <i>2705 Kirkwood Place (Kirkwood Gardens)</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Washington Sanitarium + Hosp</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Margaret</i> Last <i>Prueett</i>		4. DATE OF DEATH Month <i>6</i> Day <i>15</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-23-84</i>
9. AGE (In years last birthday) <i>74</i> yrs.		IF UNDER 1 YEAR: Months <i>7</i> Days <i>15</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home maker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>	
11. BIRTHPLACE (State or foreign country) <i>D. C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James H. Cook</i>		14. MOTHER'S MAIDEN NAME <i>GEORGIANNA COOMES</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <i>None</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT <i>Records -</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>hypertensive intracerebral hemorrhage</i> DUE TO (c) <i>10 years</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>June 6</i> , 1959, to <i>June 15</i> , 1959, that I last saw the deceased alive on <i>June 14</i> , 1959, and that death occurred at <i>11:20 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>6826 Riggs Road, Hyattsville, Md.</i> DATE SIGNED <i>June 15/59</i>			
ACTUAL SIGNATURE <i>Harvey Slickfield</i>		M.D. <i>6826 Riggs Road, Hyattsville, Md.</i>	
PHYSICIAN'S NAME (Type) <i>H. WAYNE BLACKFIELD M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6/18/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Wash. Nat'l. Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Prince Geo. County, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>WARNER E. PUMPHREY, INC.</i> <i>Raymond A. Duba</i>		24a. REC'D BY REGISTRAR DATE <i>JUN 17 '59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hana</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the attending physician. The law requires that the death certificate be signed by the attending physician and carefully filled in by the funeral director. Page 3 should be detached from the certificate as the burial-transit permit. Then please remove the pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7008 Item 21 F. 6-9-59 et  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**CERTIFICATE OF DEATH**

06989

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>4516 Traymore Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Georgia</u> Middle <u>Christine</u> Last <u>Rafferty</u>				4. DATE OF DEATH Month <u>June</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1958</u>		9. AGE (In years last birthday) <u>1</u> yrs.	IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u> IF UNDER 24 HRS: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph P. Rafferty</u>				14. MOTHER'S MAIDEN NAME <u>Angene George</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intra cerebral Hemorrhage and</u> DUE TO <u>Gastro-Intestinal Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Acute Lymphatic Leukemia</u> DUE TO (c) <u>5 months</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 days</u> <u>Weeks</u> <u>5 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	
20f. (City or town) (County) (State) <u>  </u>				20g. (City or town) (County) (State) <u>  </u>			
21. I certify that I attended the deceased from <u>March 12</u> , 19 <u>59</u> to <u>June 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 1</u> , 19 <u>59</u> , and that death occurred at <u>8:45 P</u> M, from the causes and on the date stated above							
ACTUAL SIGNATURE <u>Nathan S. Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>The Clinical Center</u> DATE SIGNED <u>6-2-59</u>			
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>				National Institutes of Health <u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6-4-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey, Bethesda, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15ME  
5M 2/57

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived - If institution: Res'dence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN 1b <u>3 days 14 1/2 hrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>57 Silver Springs</u>	
f. STREET ADDRESS <u>9314 Weaver St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Jack</u> Middle <u>Michael</u> Last <u>Reamer</u>		4. DATE OF DEATH Month <u>June</u> Day <u>17</u> Year <u>1959</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Hebrew</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-24-47</u>	
9. AGE (In years last birthday) <u>12 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Sindey H. Reamer</u>		14. MOTHER'S MAIDEN NAME <u>ANN Barkow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Hosp. Record</u>		Address <u>  </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Subdural Hemorrhage</u> <u>813X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral contusion</u> DUE TO (c) <u>Auto injury</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Struck by auto while riding bicycle</u>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Hour <u>1:30</u> p.m. Month, Day, Year <u>6-13 1959</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) (County) (State) <u>Silver Spring Monty md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>6-17-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-17-59</u>		22b. DATE THEREOF <u>George Washington</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hyattsville</u>		22d. LOCATION (City, town, or county) (State) <u>776</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Golding Funeral Home</u>		ADDRESS <u>4217 9th NW DC</u>	
24a. REC'D BY REGISTRAR DATE <u>JUN 18 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7009

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

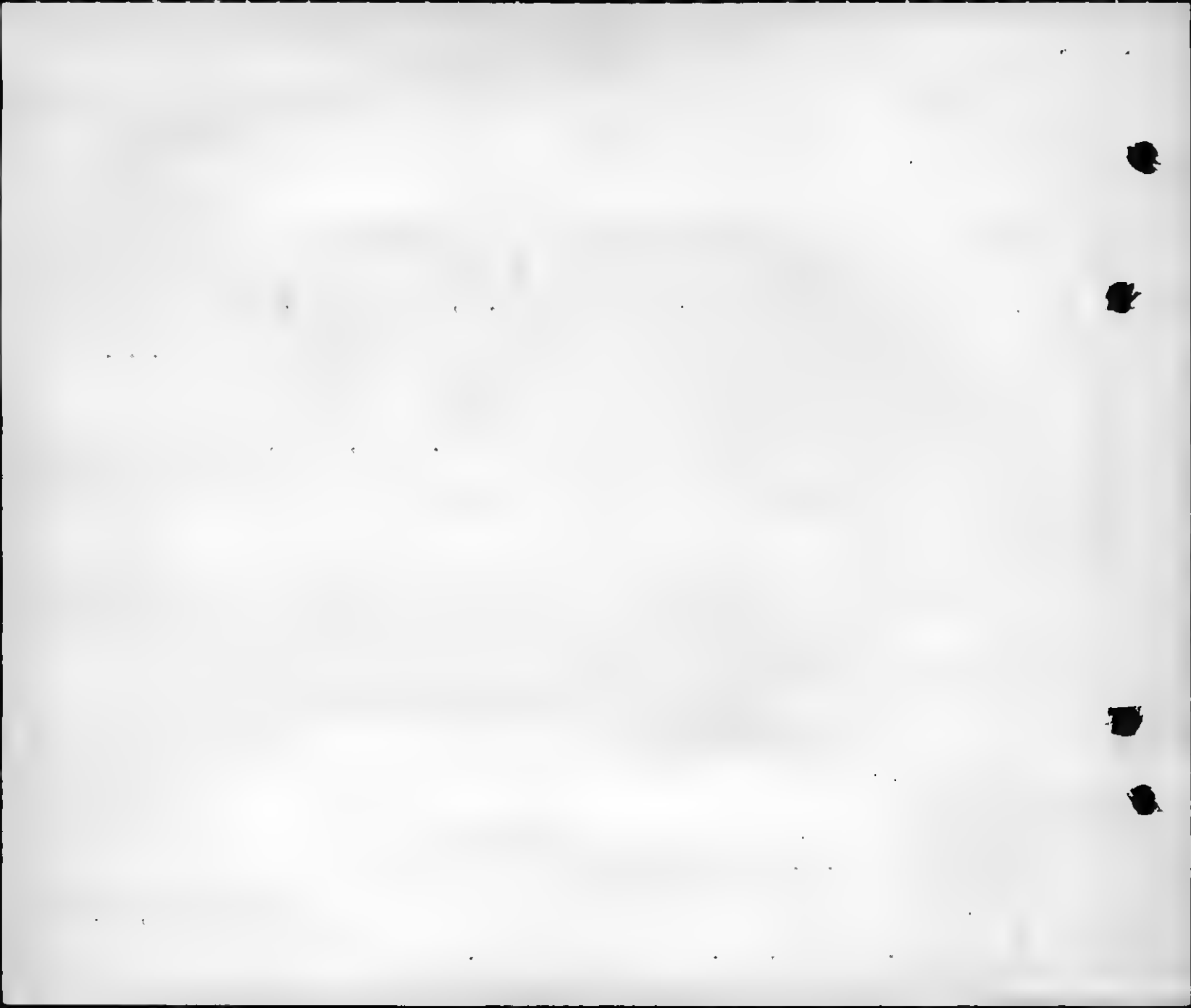
Items 11 & 12. Form G-244 5, 29/5).cac.

CERTIFICATE OF DEATH

06991

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EDNOR</b>				c. LENGTH OF STAY IN 1b <b>8 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>WATTS</b> Last <b>REDMAN</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>5</b> Year <b>59</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 3, 1874</b>		9. AGE (In years last birthday) <b>84</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Funeral Director</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Mortician</b>		11. BIRTHPLACE (State or foreign country) <b>ILLINOIS MISSOURI</b>	
13. FATHER'S NAME <b>JOSEPH SEYMOUR WICKHAM</b>				14. MOTHER'S MAIDEN NAME <b>NANCY THOMPSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>Miss Edna E. Watts, Ednor, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Syst. Hemiplegia</b> <b>450x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerosis</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>14 days</b> <b>3 years</b>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1/57</b> , 19 <b>57</b> , to <b>6/5/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/5/59</b> , 19 <b>59</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. W. BIRD</b>		M.D. <b>Sandy Spring</b>		ADDRESS (Street, city or town, state) <b>Sandy Spring, Md</b>		DATE SIGNED <b>6/6/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>6/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>MONTGOMERY COUNTY, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WARNER E. PUMPHREY, INC.</b> <b>Raymond A. Ziska</b>				ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. L. Kline</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 9 '59</b>				24b. REGISTRAR'S SIGNATURE			





7010

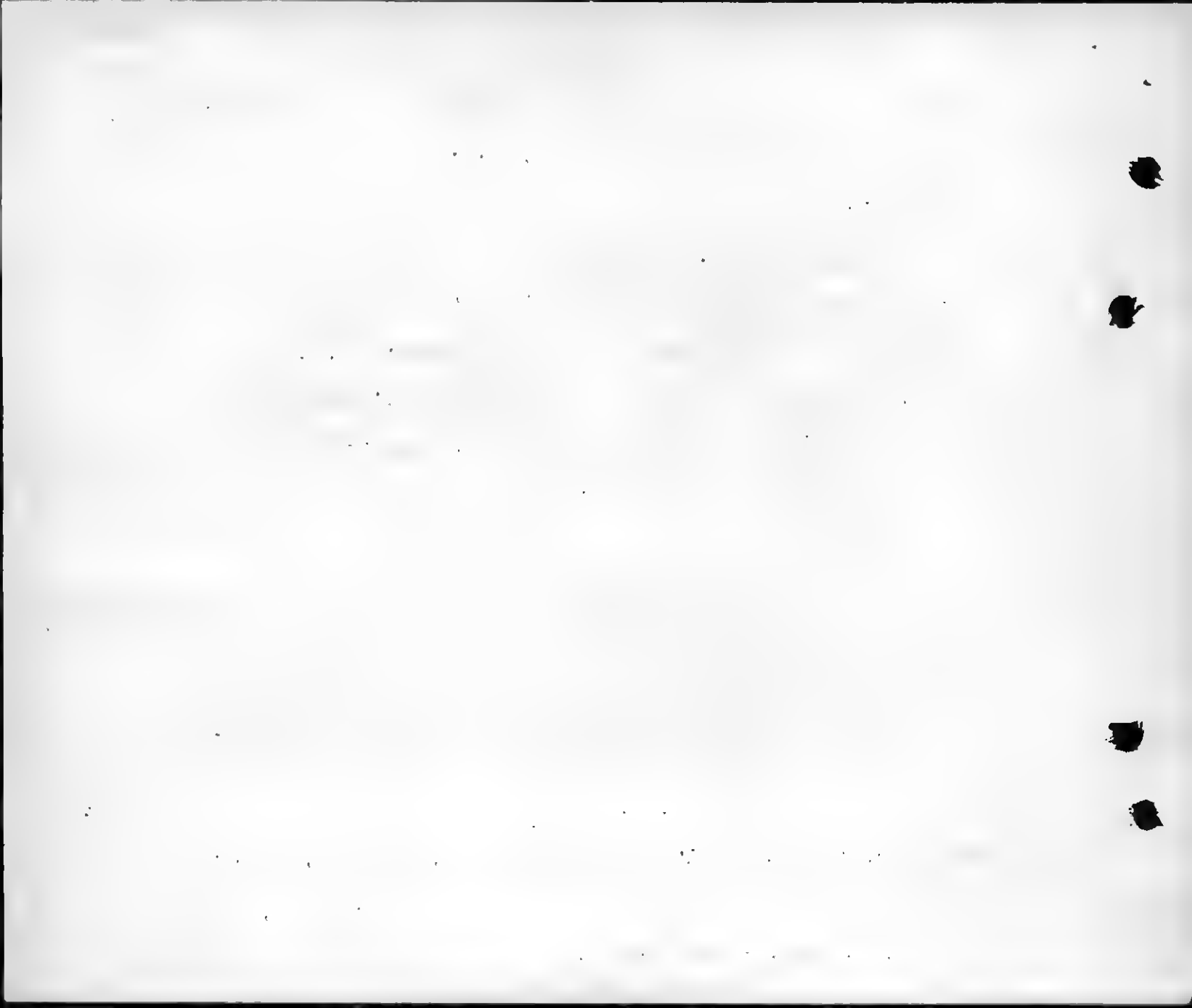
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>5860 Marbury Road</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5860 Marbury Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN R. REEVES</b> First Middle Last		4. DATE OF DEATH <b>June 1, 1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 7, 1906</b> 9. AGE (In years lost birthday) <b>52 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Legal</b>	11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>Fred W. Reeves</b>	
14. MOTHER'S MAIDEN NAME <b>Alice A. Alderman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b> (If yes, give war or dates of service) <b>WW 11</b>	
16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Lucile B. Reeves- Item # 2</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>153.3</b> DUE TO <b>metastatic Carcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of the sigmoid</b> DUE TO (c) <b>-</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8/24/1955</b> to <b>6/1/1959</b> that I last saw the deceased alive on <b>5/14/1959</b> and that death occurred at <b>3A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6/1/59</b> DATE SIGNED			
ACTUAL SIGNATURE <b>W. T. Joyce</b> M.D. PHYSICIAN'S NAME (Type) <b>W. T. Joyce 8106 Maple Ridge Road, Bethesda, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>6/1/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>	22d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>JUN 2 '59</b> DATE	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7011

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

06993

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Bethesda 14, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>9607 MONTGOMERY DRIVE</u>		d. STREET ADDRESS <u>9607 MONTGOMERY DRIVE</u>	
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>CORNELIUS</u> Last <u>REIDY</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG-29, 1886</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOVT. GUARD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOV'T.</u>	
11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.-A.</u>	
13. FATHER'S NAME <u>JOHN CORNELIUS REIDY</u>		14. MOTHER'S MAIDEN NAME <u>MCMAHON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown; If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>215-38-6714</u>	
INFORMANT		Address <u>MR. DAVID REIDY 9607 MONTGOMERY DRIVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>422.1 ACUTE CONGESTIVE HEART FAILURE</u>			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOCLEROTIC CARDIOVASCULAR DISEASE</u>			
(c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>AVICULAR FIBRILLATION; AORTIC STENOSIS</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>OCTOBER, 1954</u> , to <u>JUNE 4, 1959</u> , that I last saw the deceased alive on <u>JUNE 4, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph D. Connor, M.D.</u>		ADDRESS (Street, city or town, state) <u>9410 Old Georgetown Road</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH D. CONNOR</u>		DATE SIGNED <u>Bethesda 14, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>6-8-1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>		22d. LOCATION (City, town, or county) (State) <u>ARLINGTON, VIRGINIA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Timothy Humber</u>		ADDRESS <u>3831 GAO NW</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician on.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 6888 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06994

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN <u>Takoma Park</u> (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Sanitarium and Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lewisdale</u> d. STREET ADDRESS <u>6612 - 24th Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louis Jay Remington</u>		<b>4. DATE</b> DEATH <u>June 15 1959</u>		Month Day Year	
<b>5. SEX</b> <u>M.</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 5 1882</u>	
<b>9. AGE</b> (In years last b. (day)) <u>77</u> yrs		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Bar tender</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>retired</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Providence Rhode Island</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>		<b>13. FATHER'S NAME</b> <u>unknown</u>	
<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown by informant</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (If yes, give war or dates of service) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>—</u>	
<b>17. INFORMANT</b> <u>Hosp. records and 6612-24th pl, Lewisdale Md.</u>		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>sudden</u> (a), stating the underlying cause last. (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. 19		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that I took charge of the remains described above, held on Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>Frank J. Broschant</u> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b>	
<b>EXAMINER'S NAME (Type)</b> <u>FRANK J. Broschant</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <u>6-15-59</u>	
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>6/18/59</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cemetery</u>	
<b>22d. LOCATION (City, town, or county)</b> (State) <u>Baltimore, Md.</u>		<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>F. Gasch's Sons</u> <u>Hyattsville, Md.</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>JUN 18 '59</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 of the funeral director's report. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 2 should be used as a burial-transit permit. File pages 1 and 2 in the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

6889

CERTIFICATE OF DEATH

06995

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY <b>Washington, D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>			
c. LENGTH OF STAY IN 1b <b>Since 2-3-57</b>				d. STREET ADDRESS <b>1600 16th Street, N.W.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington San. &amp; Hosp</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>DR. Victor Bell RENCH</b>				4. DATE OF DEATH <b>JUNE 5, 1959</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-29-1870</b>	
9. AGE (In years last birthday) <b>88</b> yrs		10. MONTHS <b>8</b>		11. DAYS <b>8</b>		12. HOURS <b>8</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Physician</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John H. RENCH</b>				14. MOTHER'S MAIDEN NAME <b>Eleanor Bartlett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>obtainable R. B. RENCH</b>			
17. INFORMANT <b>3787 Benton St N.W.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, viral</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), the following cause (b) <b>Exogenous, obstructive</b> DUE TO (c) <b>Arterial Bland carcinoma</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>We wish a post mortem</b> INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>12 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>C</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>0</b> 19 <b>19</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>500 Lindwood St NW</b>				(County) (State)			
21. I certify that I attended the deceased from <b>for 2 yrs, 1957, to 9/5/1959</b> , that I last saw the deceased alive on <b>6/5/1959</b> , and that death occurred at <b>4:25 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>500 Lindwood St NW</b> DATE SIGNED <b>Chas. H. McLendon</b>							
ACTUAL SIGNATURE <b>Chas. H. McLendon</b> M.D. <b>Chas. H. McLendon</b>							
NAME (Type) <b>Chas. H. McLendon</b>							
22a. BIRTH, CREMATION, or BURIAL (Specify)		22b. DATE THEREOF <b>6/8/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Prince Georges Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos. H. Jones Jr.</b> ADDRESS <b>2901-14th St NW</b>				24a. REC'D BY REGISTRAR <b>DAVID B. '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles H. Jones</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7012

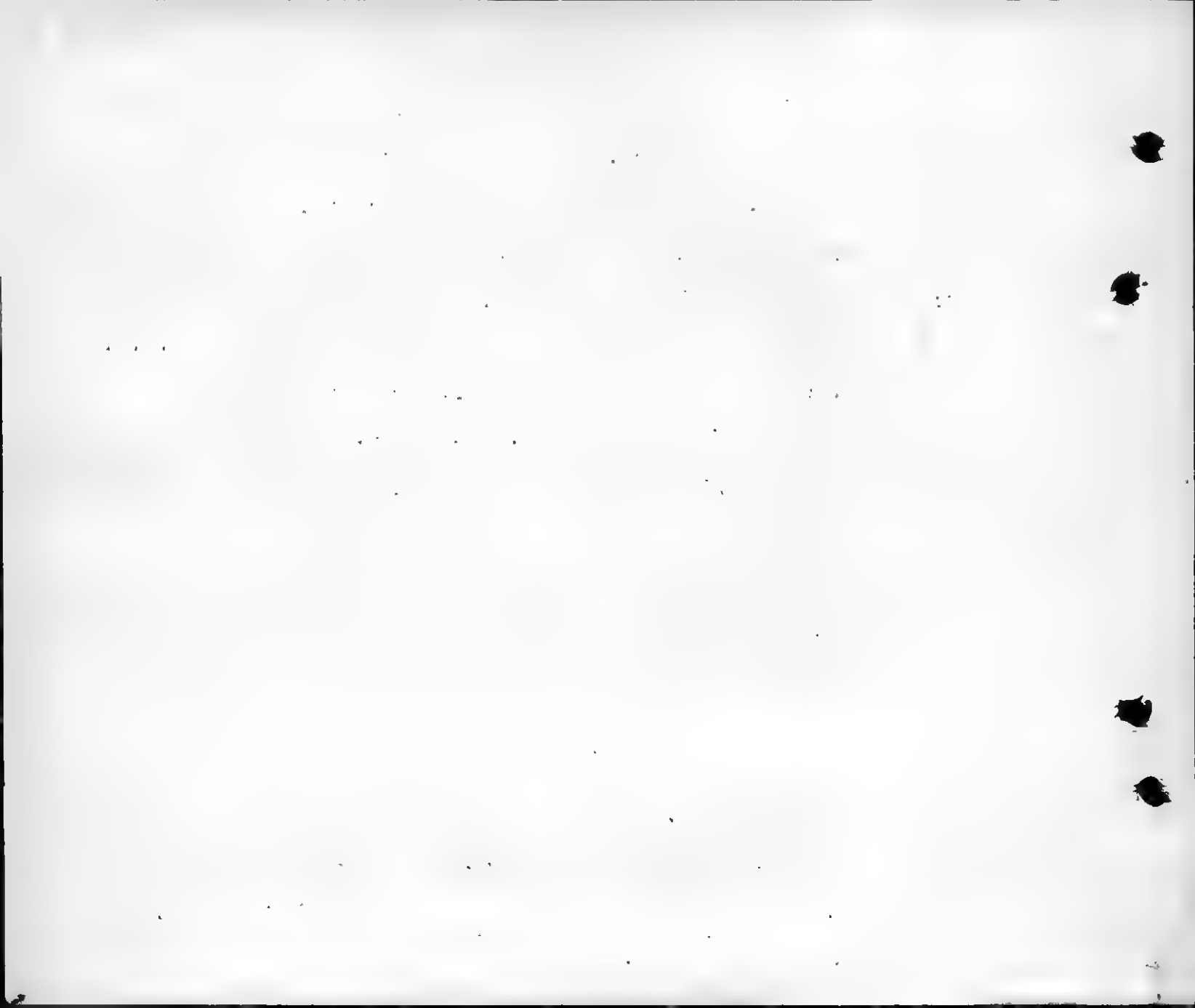
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kenwood</b>		c. LENGTH OF STAY IN lb <b>4 mo.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Kenwood</b>		d. STREET ADDRESS <b>6223 Kennedy Dr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6223 Kennedy Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Fanny</b> Middle <b>Leigh</b> Last <b>Riley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 2, 1867</b>
9. AGE (In years last birthday) <b>92 yrs.</b>		IF UNDER 1 YEAR Months <b>92</b> Days <b>92</b> Hours <b>92</b> Min. <b>92</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Mississippi</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles H. Leigh</b>		14. MOTHER'S MAIDEN NAME <b>Emily Adaline Poole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT <b>Mrs. Frances L. Denton</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia (Bronchial)</b> <b>491 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized Arteriosclerosis &amp; Myocardial failure Chronic</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 3<sup>rd</sup>, 1959</b> to <b>June 23, 1959</b> , that I last saw the deceased alive on <b>June 23, 1959</b> , and that death occurred at <b>GADAM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John B. Marbury</b>		M.D. <b>4545 Conn Ave NW</b> DATE SIGNED <b>6/23/59</b>	
PHYSICIAN'S NAME (Type) <b>John B. Marbury</b>		<b>Washington DC</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lexington, Va.</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph Lawler's Sons Inc.</b>		ADDRESS <b>1756 Pa. Ave. N.W. Washington D.C.</b>	
24a. REC'D BY REGISTRAR DATE <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR A DEDICATED PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7013

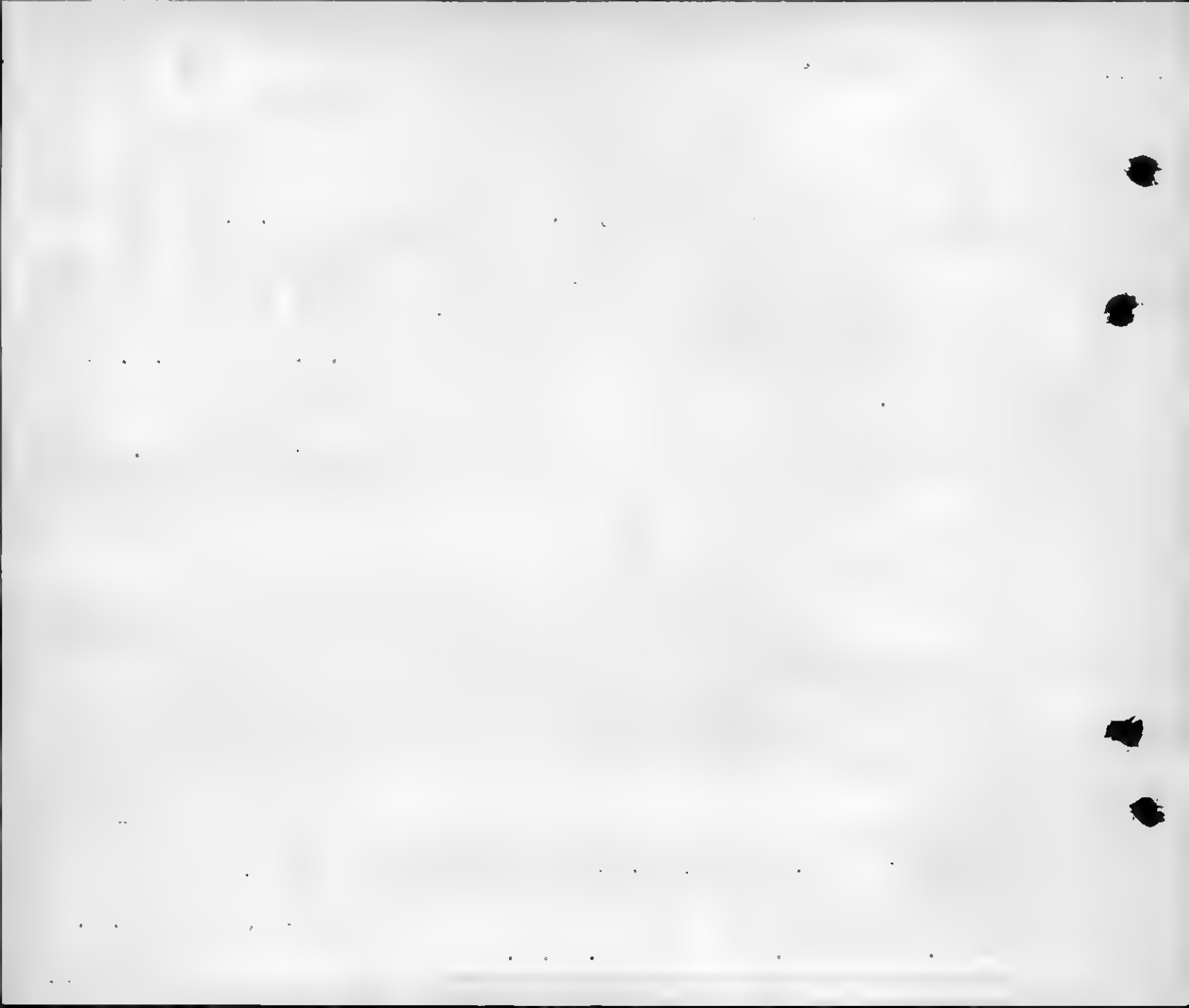
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY in 1b <b>10 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>The District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>The District of Columbia</b> d. STREET ADDRESS <b>3760 Foote Street, N. E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Roy</b> Middle <b>Earl</b> Last <b>Rodney</b>			4. DATE OF DEATH Month <b>June 27,</b> Day <b>1959</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1947</b>	9. AGE (In years last birthday) <b>12</b> yrs	IF UNDER 1 YEAR Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Washington, D. C.</b>			
12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			13. FATHER'S NAME <b>Robert E. Rodney</b>				
14. MOTHER'S MAIDEN NAME <b>Evelyn Scroggins</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				
16. SOCIAL SECURITY NO <b>None</b>			17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Md.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b> DUE TO (c) <b>Chronic Glomerulonephritis</b>					INTERVAL BETWEEN ONSET AND DEATH		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>June 17, 1959</b> to <b>June 27, 1959</b> , that I last saw the deceased alive on <b>June 27, 1959</b> , and that death occurred at <b>7:30 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Eugene B. Feigelson</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b>		DATE SIGNED <b>6-28-59</b>			
PHYSICIAN'S NAME (Type) <b>Eugene B. Feigelson, M. D.</b>		<b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>July 3, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	22d. LOCATION (City, town, or county)	(State) <b>D. C.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Rhines &amp; Co.</b>		ADDRESS <b>3015 12th St., N. E.</b>		24a. REC'D BY REGISTRAR <b>JUL 6 '59</b>	24b. REGISTRAR'S SIGNATURE <b>C. S. S. Hunt</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the burial-transit permit. Then please remove carbon copy of the certificate and file it with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached and filed as the burial-transit permit. Then please remove carbon copy of the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7014

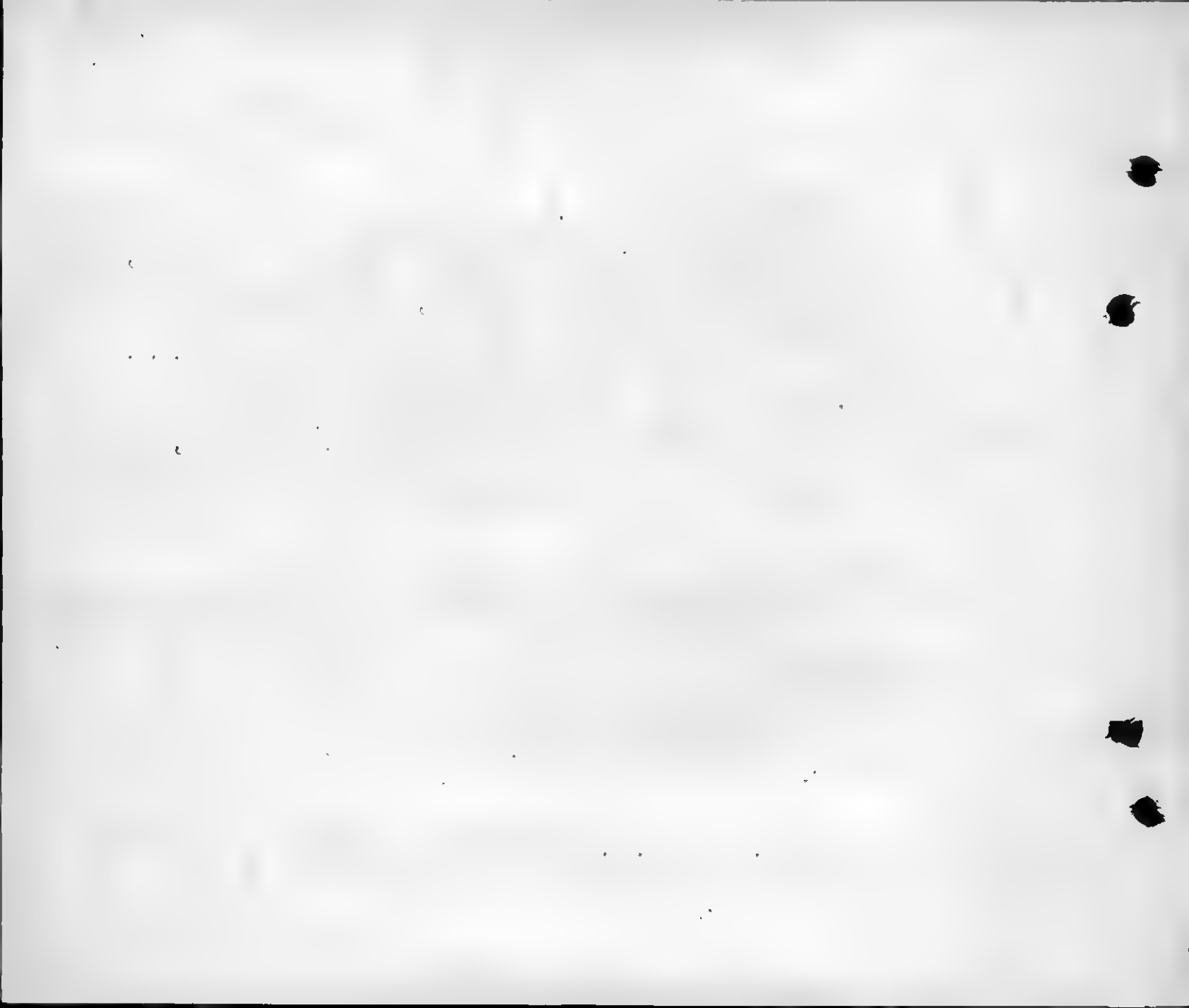
Item 19 19 11-11-59 et

## CERTIFICATE OF DEATH

06998

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>47 days</b>		2. USUAL RESIDENCE (Where deceased lived If institution- Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b> d. STREET ADDRESS <b>2348 North Early Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Robert</b> Last <b>Rogers</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 8, 1949</b>
9. AGE (In years last birthday) <b>9</b> yrs.		10. IF UNDER 1 YEAR Months <b>9</b>	11. IF UNDER 24 HRS Days <b>9</b> Hours <b>9</b> Min <b>9</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert O. Rogers</b>		14. MOTHER'S MAIDEN NAME <b>Sigrid Koski</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>The Medical Record</b>		Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <b>Gram Negative Septicaemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). <b>Bronchopneumonia</b> DUE TO (c). <b>Acute Lymphatic Leukemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 weeks</b> <b>9 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 24, 19 59</b> to <b>June 10, 19 59</b> , that I last saw the deceased alive on <b>June 10, 19 59</b> , and that death occurred at <b>9:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Nathan S. Taylor</b> PHYSICIAN'S NAME (Type) <b>Nathan S. Taylor, M. D.</b>		ADDRESS (Street, city or town, state) <b>The Clinical Center</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b> DATE SIGNED <b>6/10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>6/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Washington Natl. Cem. Arlington</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LEM Demanice</b>		ADDRESS <b>1344</b> DATE <b>JUN 12 59</b>	
24a. REC'D BY REGISTRAR <b>Arthur S. Evans</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



14 hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

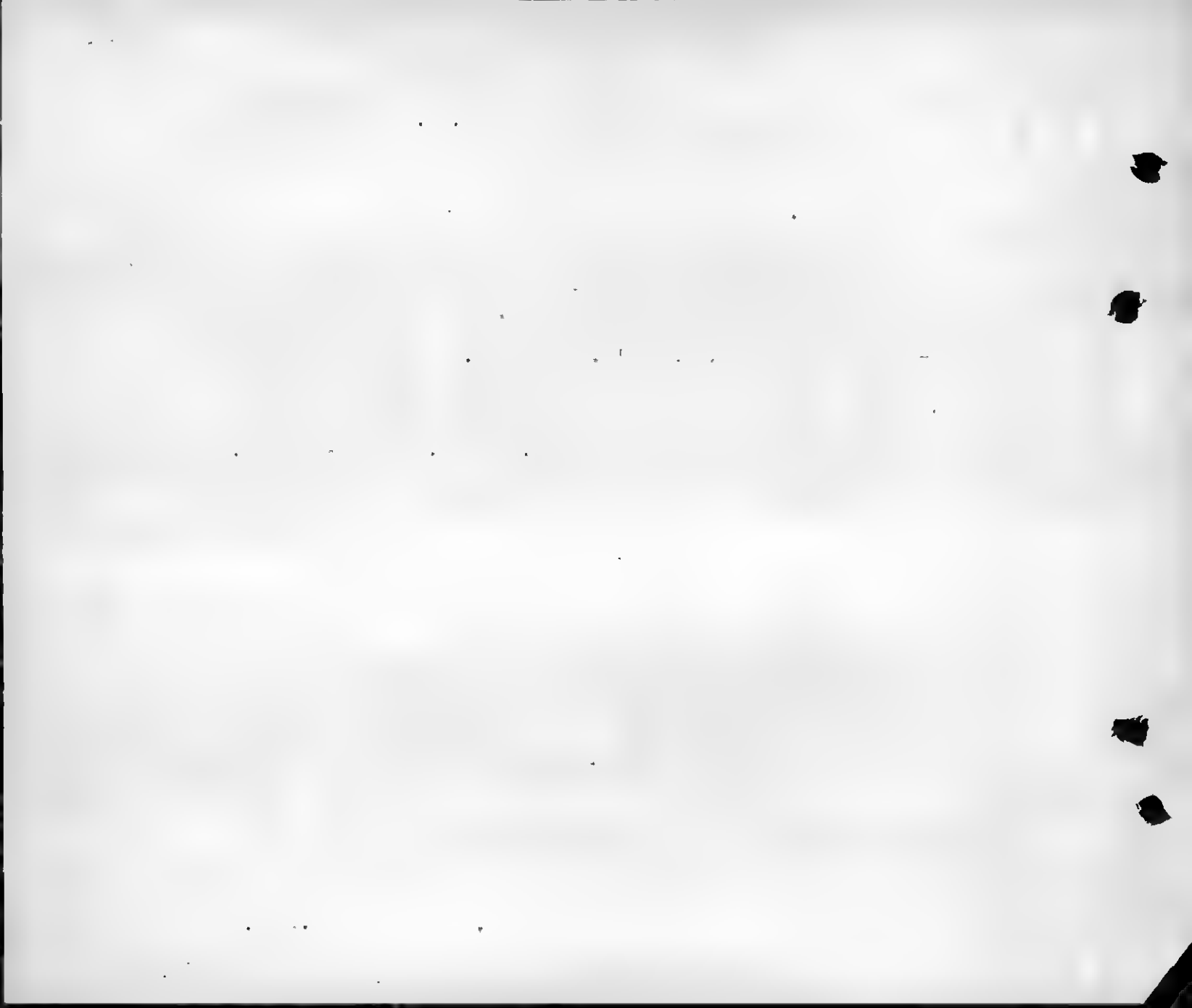
6890

## CERTIFICATE OF DEATH

06999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>D. C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>7100 Sycamore Ave. (nursing home)</u>		d. STREET ADDRESS <u>unknown</u>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Roy</u> Last <u>Roman</u>		4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>19 59</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 17, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't.</u>	
11. BIRTHPLACE (State or foreign country) <u> Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. Roman</u>		14. MOTHER'S MAIDEN NAME <u>Emma Gregory</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs. Rena R. Wailes - 110 St. Albans Way</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis - Left Side</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized &amp; Cerebral Anterior Cerebral</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August, 1954</u> to <u>30 June, 1959</u> , that I last saw the deceased alive on <u>24 June, 1959</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Russell B. Arnold</u> M.D.		ADDRESS (Street, city or town, state) <u>8801 Colesville Road, Balto., Md.</u>	
PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D. Silver Spring, Maryland.</u>		DATE SIGNED <u>6/30/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/2/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Vickers &amp; Sons - Balto</u>		24a. REC'D BY REGISTRAR <u>DATE 1 '59</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>	





7015

## CERTIFICATE OF DEATH

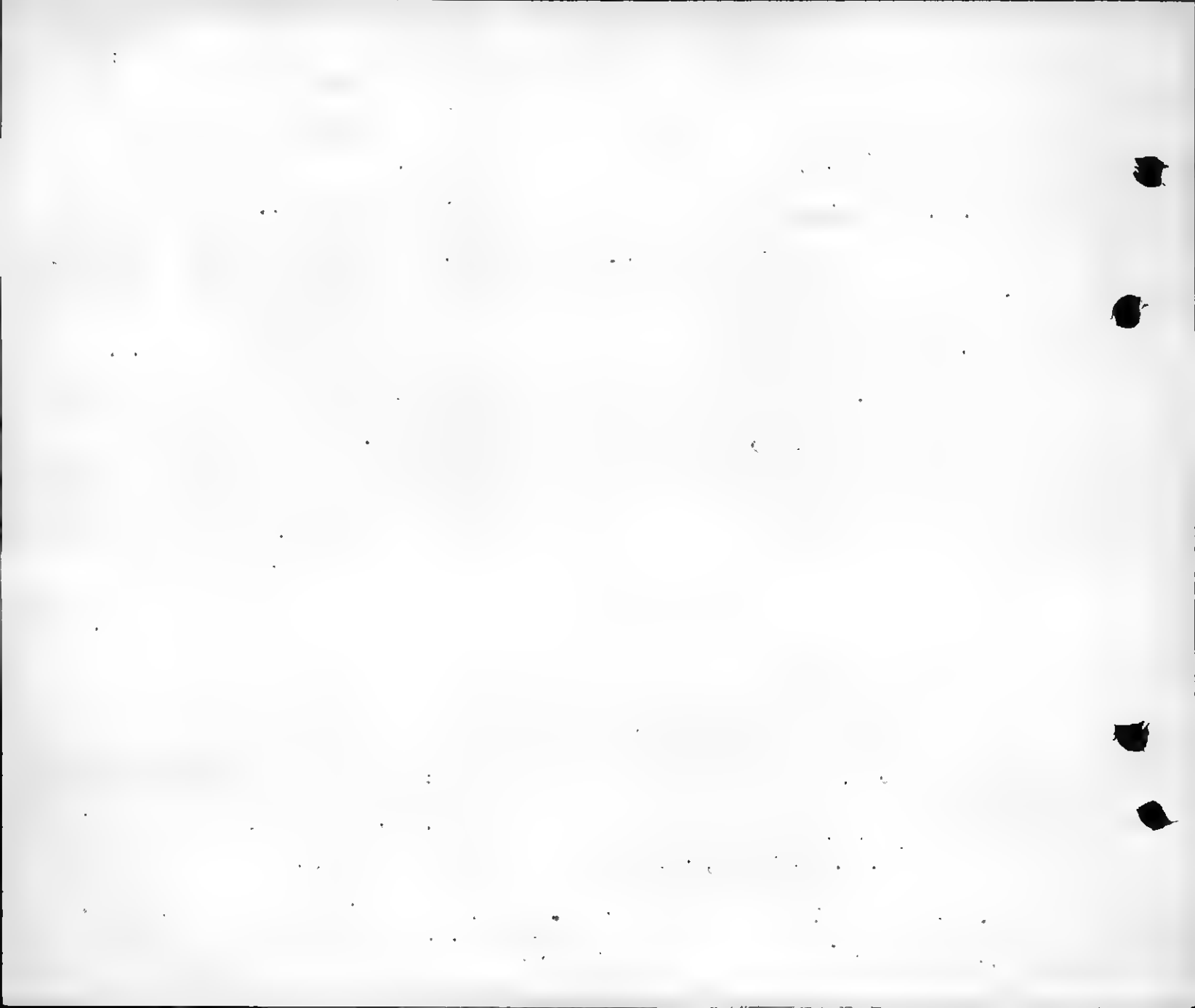
Reg. Dist. No. 215

07000

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>71 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>3701 Connecticut Ave., NW</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellis</b> Last <b>SAFFORD</b>		4. DATE OF DEATH Month <b>June</b> Day <b>17</b> Year <b>19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-1-08</b>
9. AGE (In years last birthday) <b>50</b> yrs.		10. IF UNDER 1 YEAR Months <b>50</b>	11. IF UNDER 24 HRS Days <b>50</b> Hours <b>50</b> Min. <b>50</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- - - - -</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William F. ELLIS</b>		14. MOTHER'S MAIDEN NAME <b>Katherine HAND</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>4244 to 10/45</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Artery</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Myocardial Ischemia</b> (c) DUE TO <b>Coronary Artery Obstruction</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 seconds</b> <b>"</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>April 7</b> , 1959, to <b>June 17</b> , 1959, that I last saw the deceased alive on <b>June 17</b> , 1959, and that death occurred at <b>4:07 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital</b> DATE SIGNED <b>6-18-59</b>			
ACTUAL SIGNATURE <b>F. H. O'Connell</b>		M.D. <b>U. S. Naval Hospital</b>	
PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, LT, MC, USN</b>		Bethesda 14, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	22d. LOCATION (City, town, or county) <b>Arlington Virginia</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Funeral Home, 1400 Chapin St. NW</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 22 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



## 7016 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

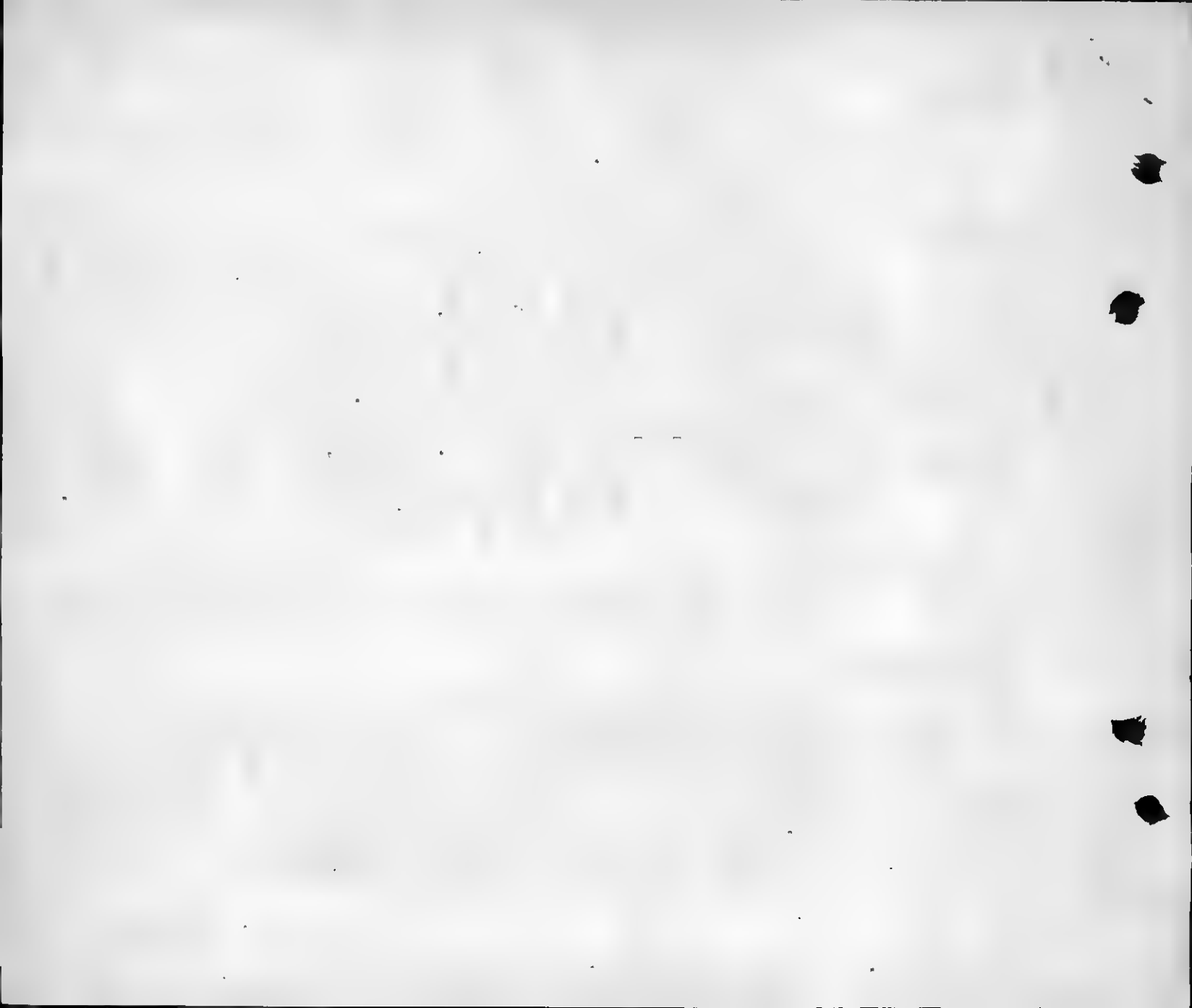
07001

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7901 Chelton Road</u>		d. STREET ADDRESS <u>7901 Chelton Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WESLEY IRVING SAUTER</u>		4. DATE OF DEATH Month Day Year <u>June 23 19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 2, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own business</u>	
11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Irving Sauter</u>		14. MOTHER'S MAIDEN NAME <u>Anna W. Lake</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO <u>214-30-0941</u>	
17. INFORMANT <u>Wesley S. Sauter, Jr</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschart</u>		DATE SIGNED <u>6/23/59</u>	
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>6/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		24a. REC'D BY REGISTRAR <u>Colburn S. Harris</u>	
ADDRESS <u>Bethesda, Maryland</u>		24b. REGISTRAR'S SIGNATURE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate as soon as possible, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, at removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 2 and 3 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7017 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07002

Reg. Dist. No.

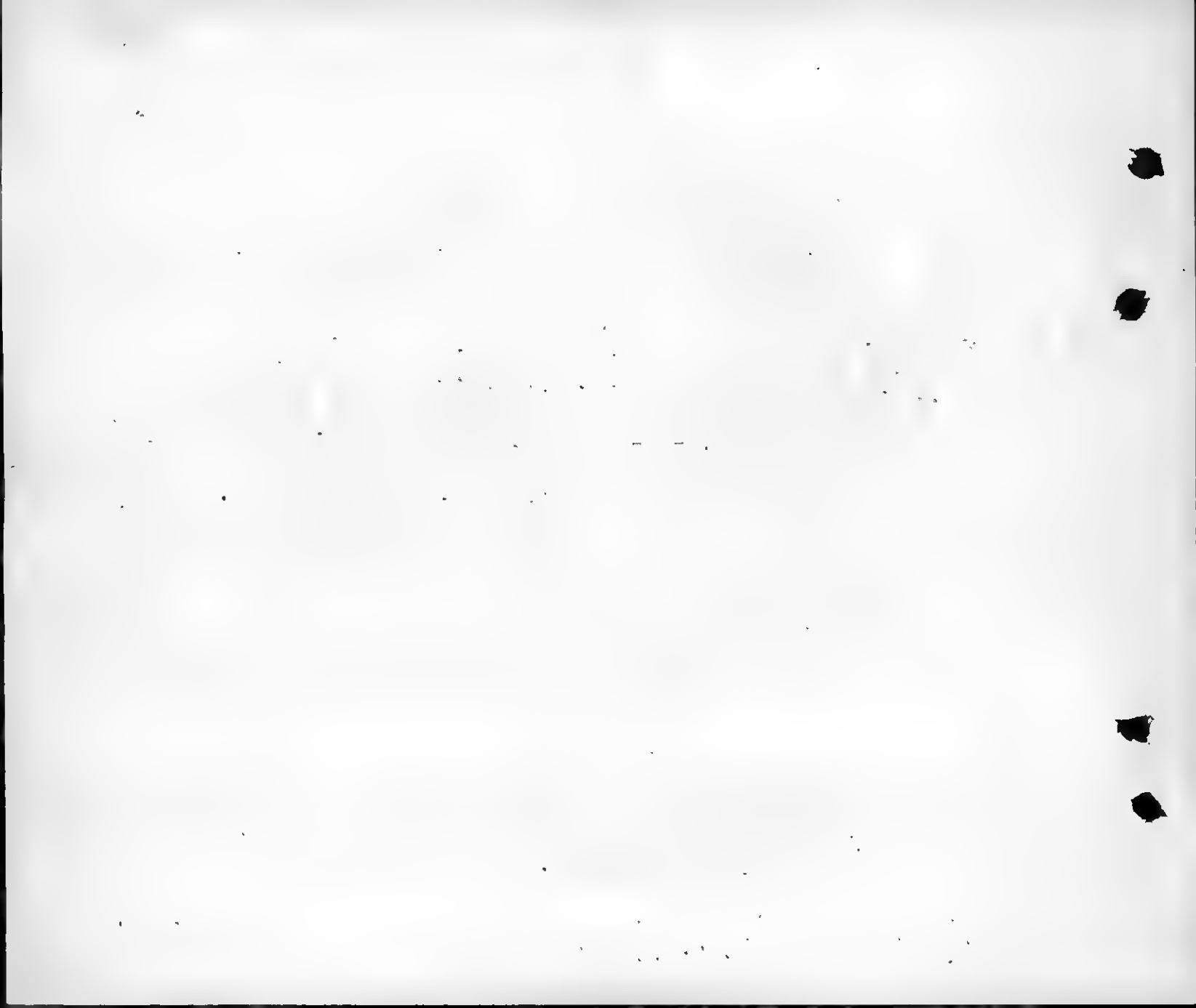
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>58</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium, 5721 Grosvenor</u>				p. STREET ADDRESS <u>12016 Centerhill Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alice</u> First <u>Welsh</u> Middle <u>Sceery</u> Last <u>Welsh</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 12, 1885</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Warren Rhode Island</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>James Welsh</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Son-Walter R. Sceery - above</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertension (years)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broscaut</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>FRANK J. Broscaut</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-trans</u>		22b. DATE THEREOF <u>6-23-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. St. Benedict</u>		22d. LOCATION (City, town, or county) (State) <u>Hartford, Connecticut</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 24 59</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>		DATE SIGNED <u>6-23-59</u>	



TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										07003
7018										CERTIFICATE OF DEATH
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>			c. LENGTH OF STAY IN 1b <u>29 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda X</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>					d. STREET ADDRESS <u>5506 Sonoma Road</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Albert</u> Last <u>Scheirer</u>					4. DATE OF DEATH Month <u>June</u> Day <u>30</u> Year <u>1959</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1895</u>		9. AGE (In years last birthday) <u>64</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (State or foreign country) <u>Elmira, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>James W. Scheirer</u>					14. MOTHER'S MAIDEN NAME <u>Clara Benton</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO <u>578-32-6016</u>		INFORMANT <u>Miss Nellian Scheirer</u> Address <u>5506 Sonoma Rd Bethesda, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]										
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute Congestive Heart Failure.</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>Acute Post. Myocardial Infarction</u> DUE TO <u>40hr</u> (c) _____										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month <u>19</u> Day <u>30</u> Year <u>1959</u> Hour <u>6:30</u> a. m. <u>19</u> p. m.			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/29</u> <u>1</u> , 19 <u>59</u> , to <u>6/30</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>6/30</u> , 19 <u>59</u> , and that death occurred at <u>10:30</u> P.M. from the causes and on the date stated above.										
ACTUAL SIGNATURE <u>A. J. Brennan</u> M.D. <u>Bethesda, Md</u>					DATE SIGNED <u>6/30/59</u>					
PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>cremation</u>			22b. DATE THEREOF <u>7/3/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Crematory</u>			22d. LOCATION (City, town or county) (State) <u>Prince George, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>She S. H. Hines</u>					24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director. Pages 1 and 2 should be filled with the information regarding the deceased. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information regarding the deceased. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information regarding the deceased.

7019

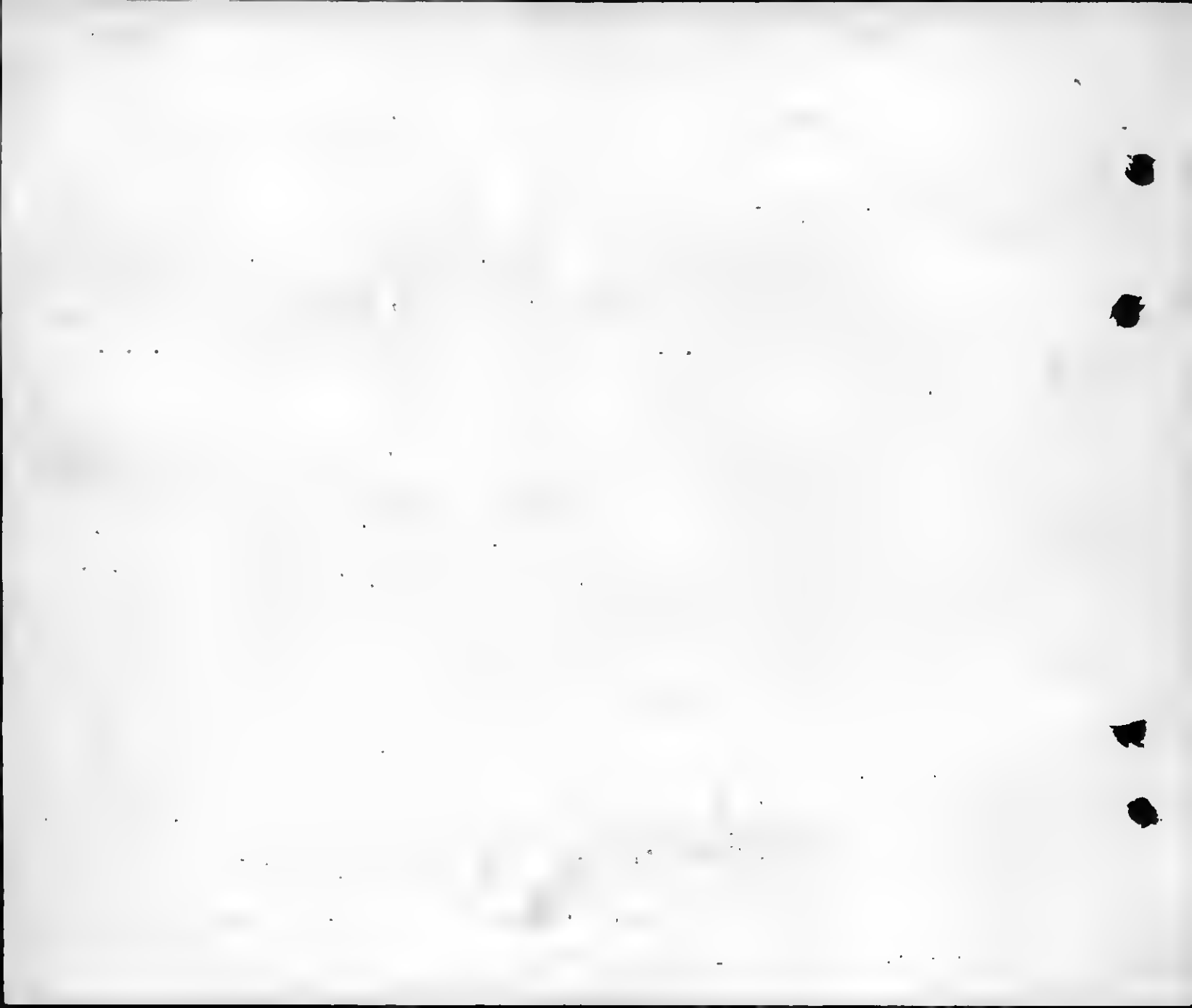
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland-</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Suburban Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W</b> Last <b>Schley</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 20, 1901</b>
9. AGE (In years last birthday) yrs <b>58</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pump operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Engineers</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Roberts</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b></b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO <b>Cardiac Arrest</b> (b) <b>Coronary Occlusion</b> DUE TO <b></b> (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b> <b>1/2 hour</b> <b>48 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 1958</b> to <b>6/23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/23</b> , 19 <b>59</b> , and that death occurred at <b>6:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank Y. Jagers, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>5707 Wisconsin Ave.</b> DATE SIGNED <b>6/23/59</b>	
PHYSICIAN'S NAME (Type) <b>Frank Y. Jagers, Jr.</b>		<b>Cherry Chase 15, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/25/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Potomac Church Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Potomac, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 25 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kenna</b>



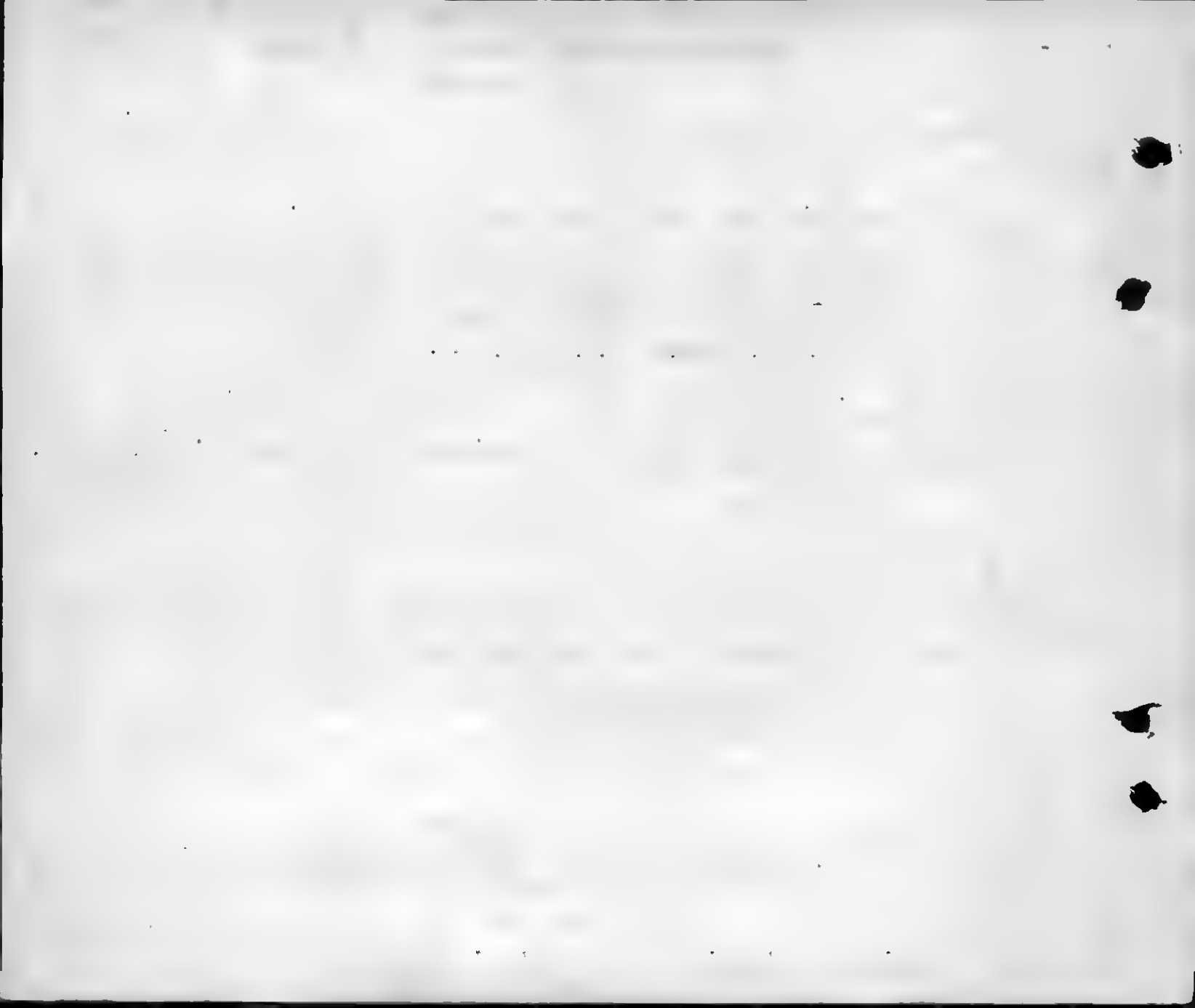
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 7020 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07005

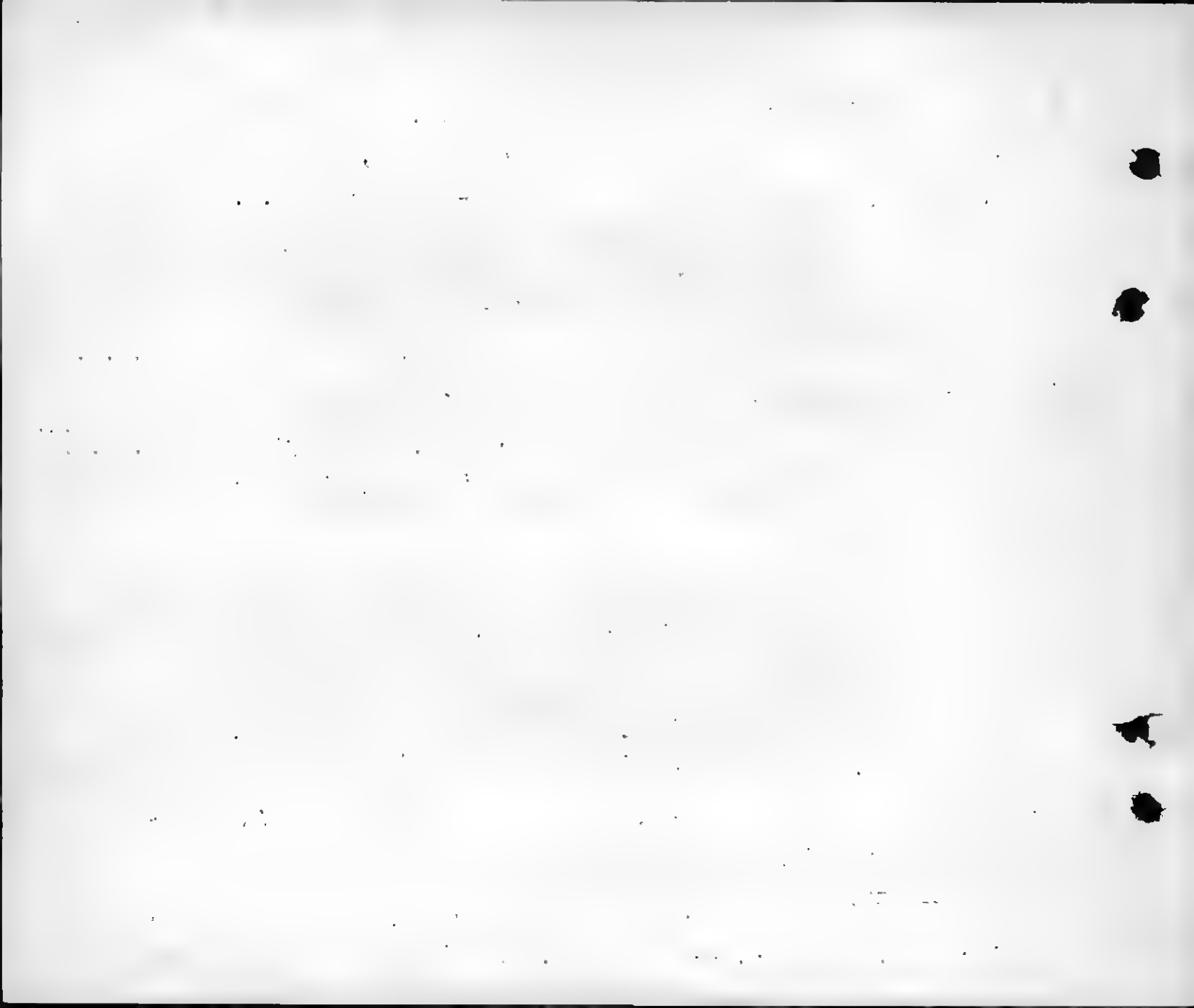
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ethesda</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hosp.</u>				d. STREET ADDRESS <u>1300 Hewitt Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Benjamin</u> Last <u>Schrider</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 59</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/1994</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired -Asst. Sec. Chief.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't. D.C.</u>		11. BIRTHPLACE (State or foreign country) <u>  </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin F. Schrider</u>				14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXXXX Annie McGuire</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Jerome P. Schrider, 376 Ralph Rd. Silver Spring</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>  <u>400.1</u> DUE TO  Conditions, if any, which gave rise to immediate cause (b) <u>  </u>  (c) <u>  </u>  DUE TO  (c) <u>  </u>  DUE TO  (c) <u>  </u> </p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u></p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u></p> </div> </div>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Montgomery County, Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Giska, mgr.</u>				ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the body and "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove棺盒, paper, etc. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

100-2,22 1-1-19-2-2 6-15-59 et

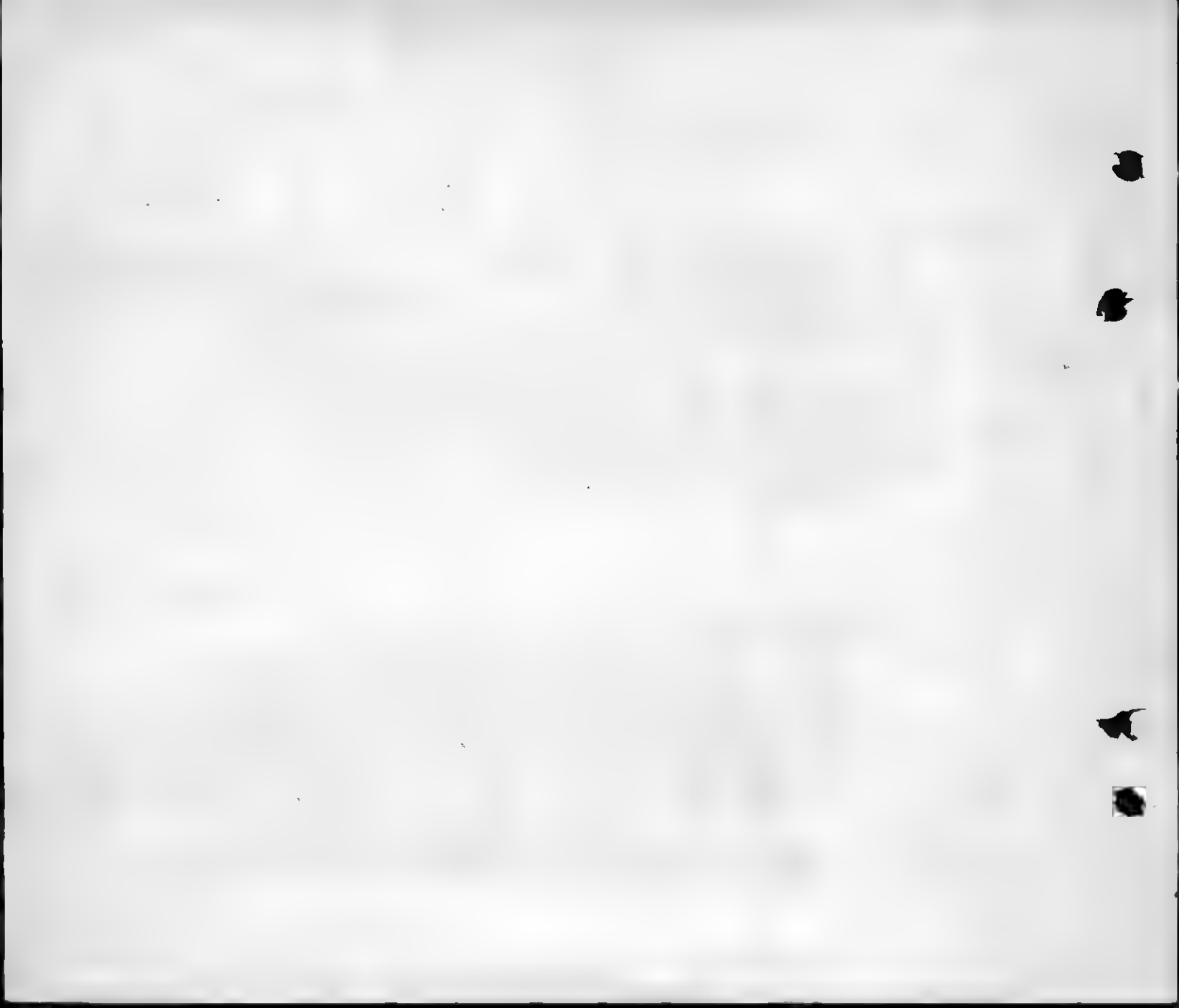
7021

CERTIFICATE OF DEATH

07007

Reg. Dist. No.

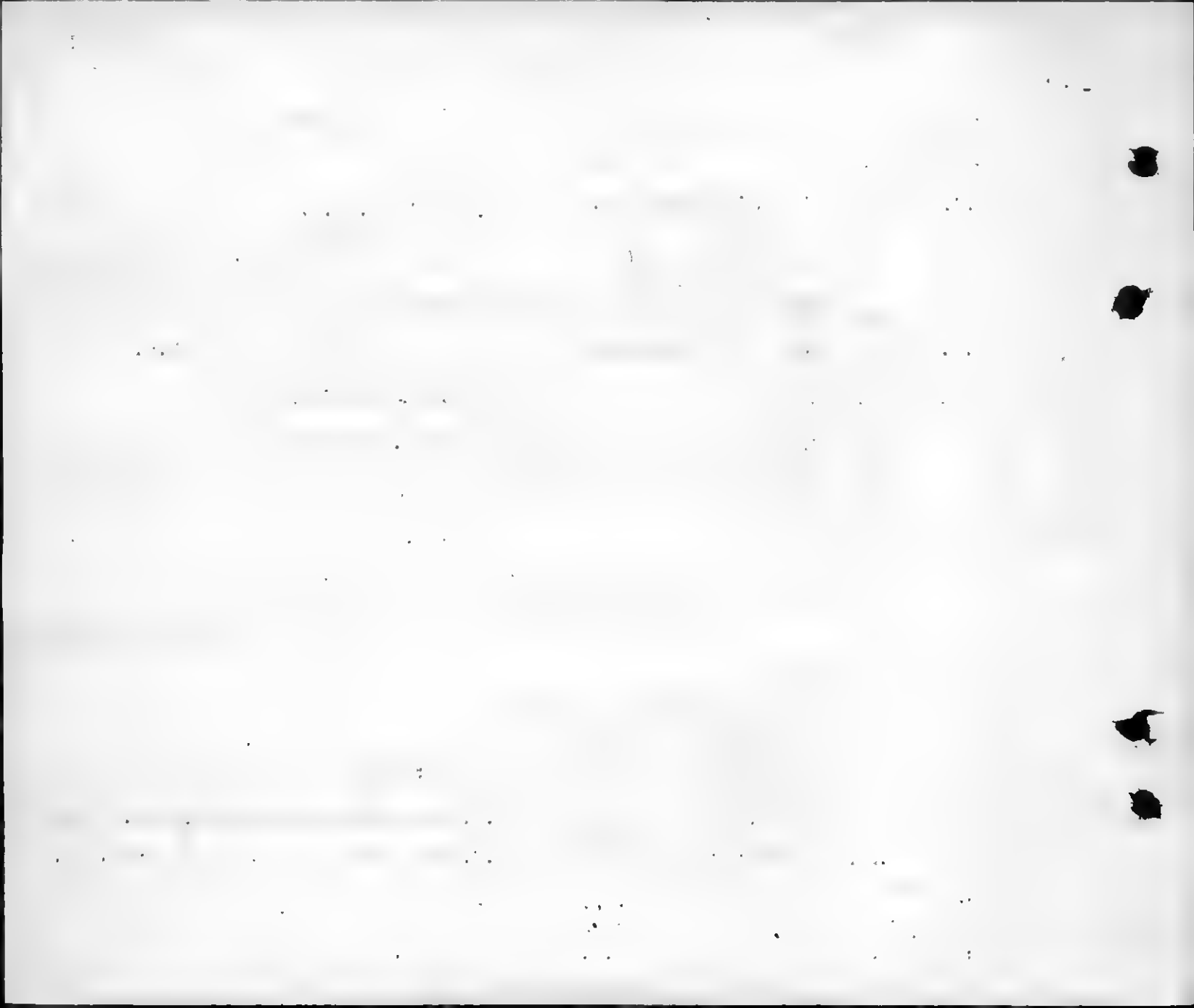
1 PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WASHINGTON</u> b. COUNTY <u>DC</u> <u>4</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4600 5th St. N.W.</u>	
c. LENGTH OF STAY IN 1b <u>8 WKS.</u>		d. STREET ADDRESS <u>GREEN'S NURSING HOME - 14326 Collesville Rd</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GREEN'S NURSING HOME - 14326 Collesville Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>ELIZABETH ANN SEBASTIAN</u>		4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1959</u>	
5 SEX <u>FE</u>	6 COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2-23-1893</u>
9. AGE (in years last birthday) <u>66</u> yrs.		10. UNDER 1 YEAR <input type="checkbox"/> UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BEAUTICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>19-051156</u>	
17. INFORMANT <u>Coie Kendrick</u>		Address <u>7606-23rd Ave W Hyattsville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> 1558 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA, COLON</u> DUE TO (c) <u>10 Mos</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 Mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JULY</u> 19 <u>51</u> , to <u>June 4</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>JUNE 1</u> , 19 <u>59</u> , and that death occurred at <u>5:00</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Herbert Brandes</u> M.D.		ADDRESS (Street, city or town, state) <u>400 W ST. NE - DC</u> DATE SIGNED <u>JUNE, 59</u>	
PHYSICIAN'S NAME (Type) <u>HERBERT BRANDES, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6-8-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wash D.C.</u>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mattingly's</u> ADDRESS <u>131 - 11th St., S. E., Wash., D.C.</u>		24a. REC'D BY REGISTRAR <u>JUN 8 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>





TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the information required by the attending physician and completed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
7022									
CERTIFICATE OF DEATH									
Reg. Dist. No. 215									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>45 minutes</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U.S. Naval Hospital, Bethesda, Md.</b>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>District of Columbia</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1609 30th St. S.E.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>Adolph</b> Middle <b>(n)</b> Last <b>SEIDLER</b>					4. DATE OF DEATH Month <b>June</b> Day <b>5</b> Year <b>1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3 November 1881</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Marine Corps</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>William SEIDLER</b>					14. MOTHER'S MAIDEN NAME <b>Wilhelmina KOPLIN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1900 to 1932</b>					16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>(Wife) Nora P. SEIDLER Same as #2</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> 421.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary insufficiency</b> DUE TO (c) <b>Arteriosclerotic heart disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 min.</b> <b>yes</b> <b>10 yrs</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>5 June</b> , 19 <b>59</b> , to <b>5 June</b> , 19 <b>59</b> that I last saw the deceased alive on <b>5 June</b> , 19 <b>59</b> , and that death occurred at <b>10:30AM</b> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>R.G. Galbraith</b>					ADDRESS (Street, city or town, state) <b>U.S. Naval Hospital, Bethesda Md. 6-559</b> DATE SIGNED				
PHYSICIAN'S NAME (Type) <b>R.G. GALBRAITH LT MC USN</b>					U.S. Naval Hospital, NNMC, Bethesda, Md.				
22a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>			22b. DATE THEREOF <b>June 9/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee's 4th and Massachusetts Ave N.W. Washington</b>					24a. REC'D BY REGISTRAR <b>D. JUN 9 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Huns</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

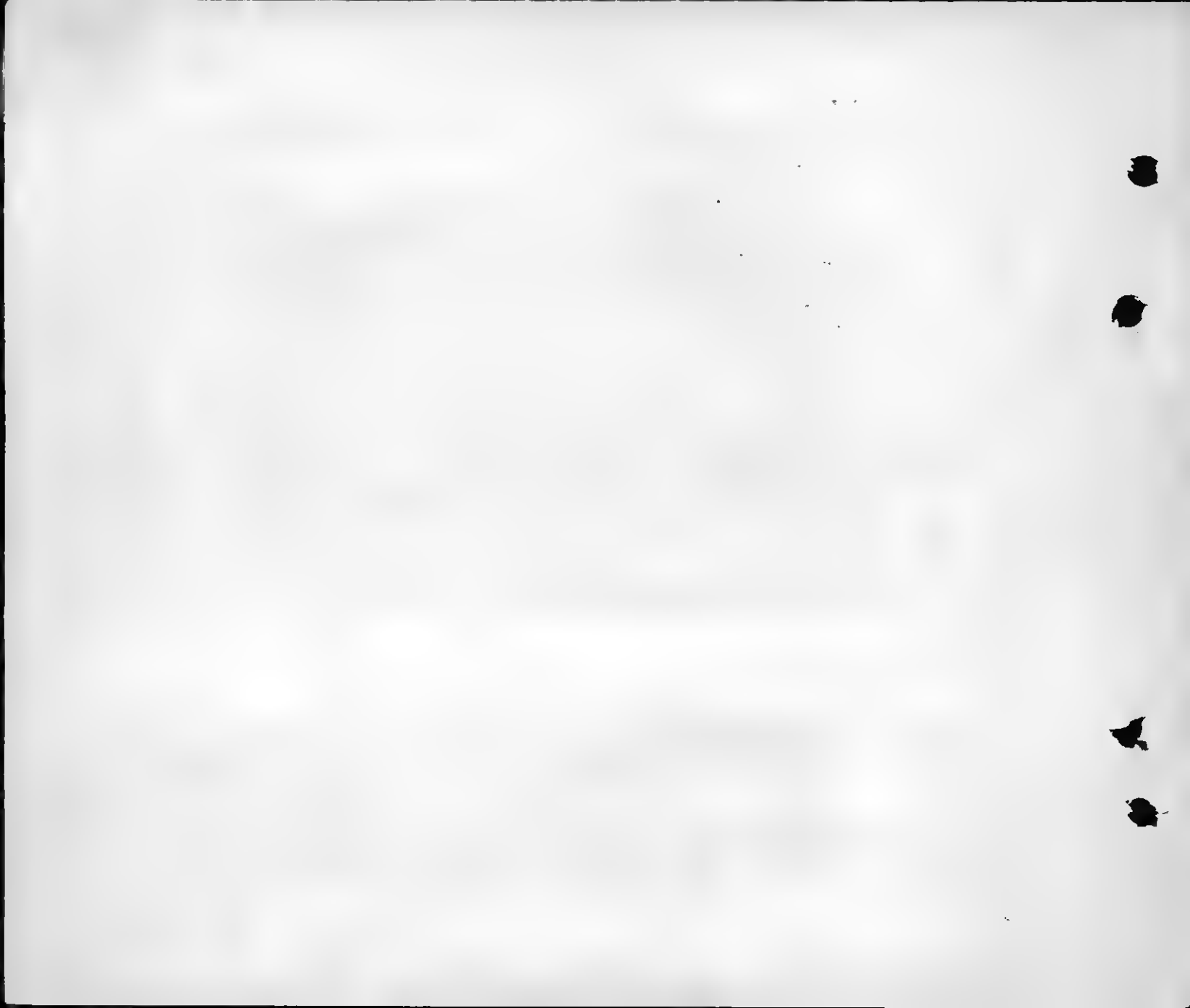
7023

CERTIFICATE OF DEATH

07009

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) o. STATE <u>Wash. D.C.</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>47x-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Fairland Nursing Home</u>		d. STREET ADDRESS <u>1612 Portal Drive N.W.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles Seligson</u>		4. DATE OF DEATH Month Day Year <u>June 30 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 21, 1884</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Seligson</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca ---</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>052-10-6446</u>	
17. INFORMANT <u>Leo Seligson - 1612-Portal Dr. N.W.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Intestine, Colon</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct. 1958</u> to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 29</u> 19 <u>59</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>915-19th St. N.W.</u> <u>6-30-59</u>			
ACTUAL SIGNATURE <u>Isidore Shulman</u>		M.D. <u>WASH. D.C.</u>	
PHYSICIAN'S NAME (Type) <u>ISIDORE SHULMAN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7-1-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>King David Mem. Garden Falls Church, Va.</u>		22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. Dargatzis &amp; Sons - Wash. D.C.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 2 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give pages 1, 2, or 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MS A15-111  
5M 2/57

7024

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Florida</u> b. COUNTY <u>DeKalb</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carol City</u> 42X	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Visitor in private home</u>		d. STREET ADDRESS <u>3765 N.W. 176<sup>th</sup> St</u>	
3. NAME OF DECEASED (Type or print) <u>William Swift Skerrell</u>		4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-29-1883</u>
9. AGE (in years last birthday) <u>75</u> yrs		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1st Col U.S.A</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Ala</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.C</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>XXXXXXXXXX Ida Legg</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> WW # <u>1&amp;2</u>		16. SOCIAL SECURITY NO <u>218-24-0896</u>	
17. INFORMANT <u>Mable Skerrell (wife)</u>		Address <u>Item 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 42.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c), stating the underlying cause last, (c) <u>  </u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Frank J. Broschert</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>6-3-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/5/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Bishop</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneave</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and carefully filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
15M 9/55

7025 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

07011

Reg. Dist. No.

Weight 8 lbs 13 oz

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>		d. STREET ADDRESS <u>3907 MERTFORD ST</u>	
3. NAME OF DECEASED (Type or print) First <u>BABY</u> Middle <u>GRACE</u> Last <u>SIMPSON</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>15</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 14 1959</u>
9. AGE (In years lost birthday) yrs. <u>5</u> Months <u>25</u> Days <u>1</u> Hours <u>25</u> Min. <u>25</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JACKIE DEORA SIMPSON</u>		14. MOTHER'S MAIDEN NAME <u>ALICILIA CUTLER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MOTHER</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemolytic disease of the newborn</u> <u>170.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>—</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 14, 1959</u> , to <u>June 15, 1959</u> , that I last saw the deceased alive on <u>June 15, 1959</u> , and that death occurred at <u>3:30 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.		ADDRESS (Street, city or town, state) <u>809 View Hill Rd. Rockville, Md.</u> DATE SIGNED <u>6/15/59</u>	
PHYSICIAN'S NAME (Type) <u>JAMES S. STANTON MD</u>		<u>809 View Hill Rd. Rockville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/16/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sandy Spring</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert C. Shawden</u>		ADDRESS <u>Rockville, Md.</u> REC'D BY REGISTRAR DATE <u>JUN 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

78 pbn.  
no footer  
- Rochester NY 21-



7026

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

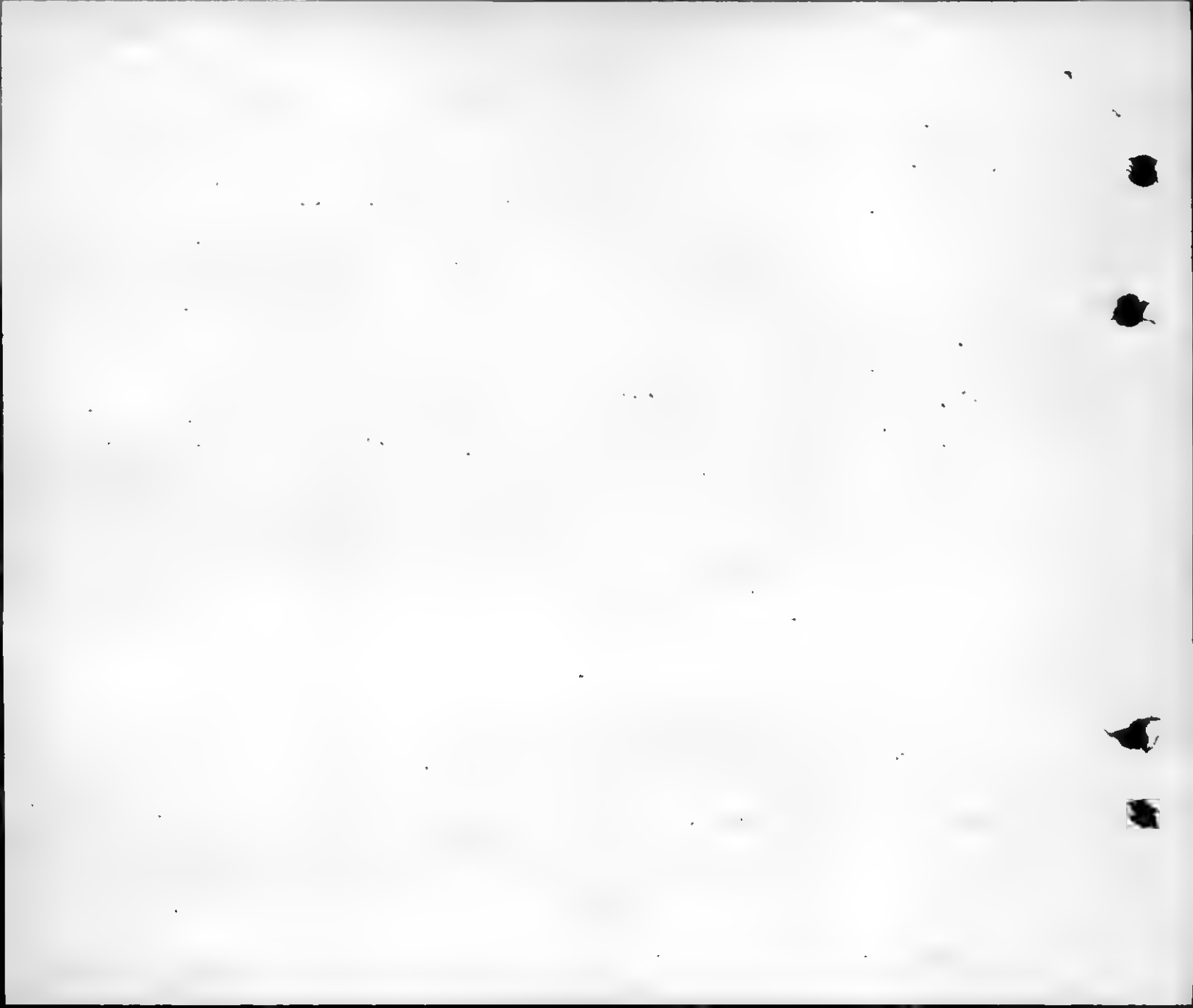
07012

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institut on Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban</u>		d. STREET ADDRESS <u>14342 Montg. Ave.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>White</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-8-80</u>
9. AGE (In years last birthday) <u>79</u> yrs	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Georgia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>MaKajak White</u>		14. MOTHER'S MAIDEN NAME <u>Willie Sewell</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>No</u>	
17. INFORMANT <u>Willie White Smith</u>		Address <u>4342 Bethesda Montgomery Ave</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic hypertensive cardiovascular disease</u> (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>	
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>59</u> , to <u>June 6</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>June 6</u> , 19 <u>59</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. C. Buchanan</u>		DATE SIGNED <u>June 6, 1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. C. Buchanan</u>		M.D. <u>Note: This patient has been known to our office and under the care of my associate Dr. T. J. Abernethy for a number of years.</u>	
22a. INFORMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Thomson, Ga. Cem.</u>	22d. LOCATION (City, town, or county) <u>Thomson, Georgia</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Maryland</u>	
24a. REC'D BY REGISTRAR <u>—</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

7027

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

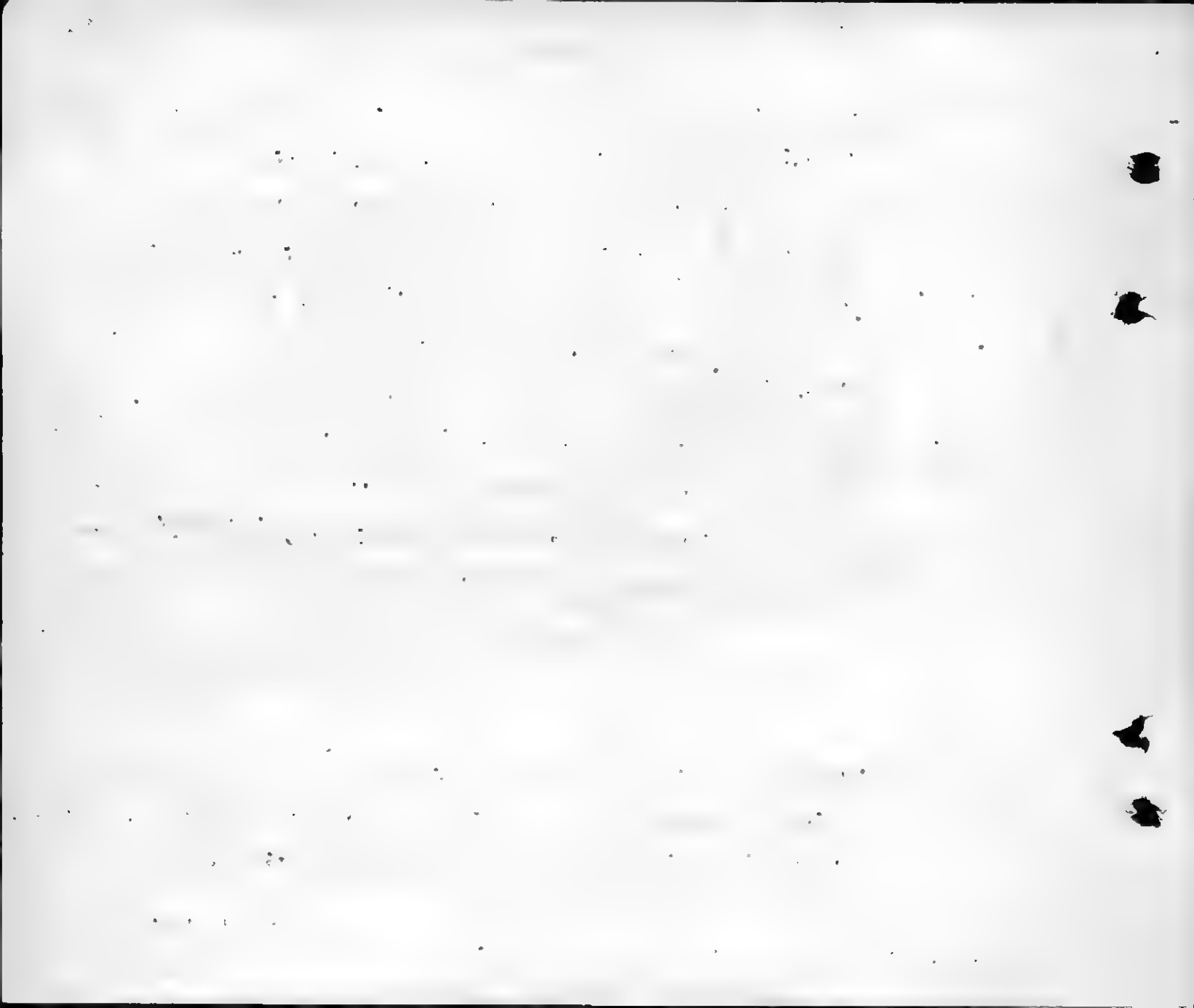
CERTIFICATE OF DEATH

07013

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>9 YEARS.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1908 GLEN ROSS ROAD.</u>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HARRY ELBERT SMITH</u>		4. DATE OF DEATH Month Day Year <u>JUNE 5 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 16, 1886</u>
9. AGE (In years last birthday) <u>72 XXXYrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ELECTRICIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>MINNESOTA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL SMITH.</u>		14. MOTHER'S MAIDEN NAME <u>LOTTIE CLIFT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE.</u>	
17. INFORMANT <u>MRS EVA SMITH</u>		Address <u>1908 GLENROSS RD SPRING, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>CORONARY ARTERY DISEASE AND MYOCARDIAL ISCHOMIA</u> (c) <u>CORONARY ATHEROSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 YEARS</u> <u>2 YEARS</u> <u>2 YEARS.</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>SEPT. 1954</u> to <u>JUNE 5, 1959</u> that I last saw the deceased alive on <u>JUNE 5, 1959</u> , and that death occurred at <u>5:25 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>8907 GEORGIA AVENUE WASHINGTON, D. C.</u> DATE SIGNED <u>JUNE 5, 1959</u>			
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/8/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> ADDRESS <u>Silver Spring, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 59</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Raymond A. Ziska</u>			

MEDICAL CERTIFICATION



7028

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

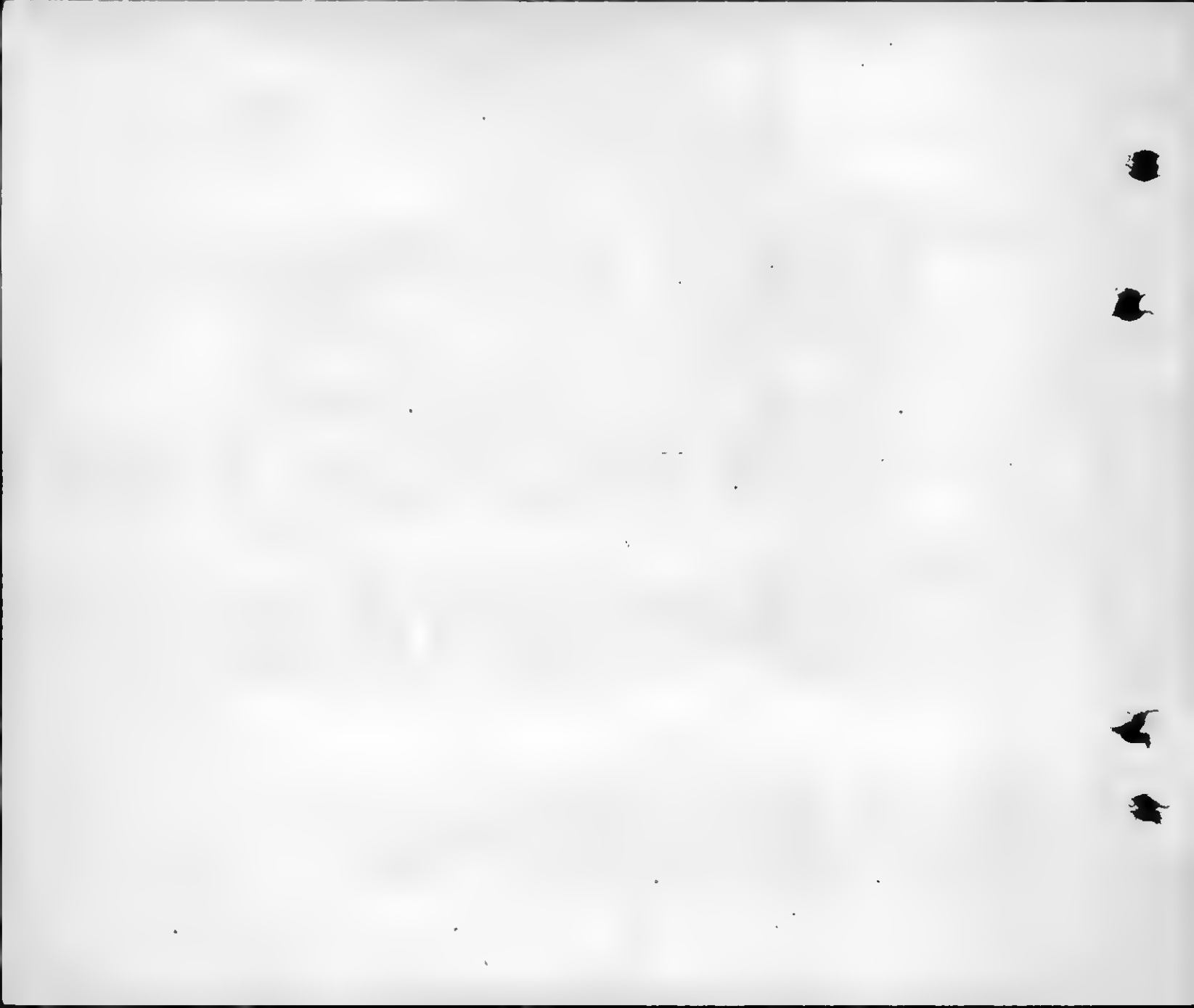
07014

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b> c. LENGTH OF STAY IN 1b <b>1 DAY</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MONTGOMERY COUNTY GENERAL HOSPITAL</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAMASCUS</b> d. STREET ADDRESS <b>RIDGE ROAD</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>GRACE ELIZABETH SNAPP</b>				4. DATE OF DEATH Month Day Year <b>JUNE 1 19 59</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/9/91</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 74 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>JAMES M. RUDASILL</b>				14. MOTHER'S MAIDEN NAME <b>IDA E. GRANBSTAFF</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>HOSPITAL RECORDS,</b>		Address <b>OLNEY, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY— IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>420.0</b> DUE TO <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus - 7 years</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>DAMASCUS</b>				20g. (County) <b>DAMASCUS</b>		20h. (State) <b>MARYLAND</b>	
21. I certify that I attended the deceased from <b>May 1957</b> to <b>June 1, 1959</b> that I last saw the deceased alive on <b>June 1, 1959</b> , and that death occurred at <b>3:15 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>185 Russell Ave. Damascus, Md. 6-1-59</b> DATE SIGNED <b>6-1-59</b>							
ACTUAL SIGNATURE <b>J. Schumacher</b> NAME (Type) <b>J. SCHUMACHER, M. D.</b>				GALITHERSBURG, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 2, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Damascus Meth.</b>		22d. LOCATION (City, town, or county) (State) <b>Damascus, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clara L. Moleworth</b> ADDRESS <b>Damascus, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 4 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07015

7029

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN TB <b>29 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The Clinical Center, Bethesda 14, Md.</b>		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>14</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>455 Old Home Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Daniel Jacob Staup</b>		4. DATE OF DEATH Month <b>June</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 6, 1906</b>
9. AGE (In years last birthday) <b>53</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Welder &amp; Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Alex Staup</b>	
14. MOTHER'S MAIDEN NAME <b>Susan Wilson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WW II</b>	
16. SOCIAL SECURITY NO. <b>215-07-0929</b>		17. INFORMANT <b>The Medical Record</b> Address <b>The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MALIGNANT MELANOMA</b> <b>190.9</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>1 year &amp; 6 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 12</b> , 19 <b>59</b> , to <b>June 10</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 10</b> , 19 <b>59</b> , and that death occurred at <b>12:25 A.</b> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED <b>The Clinical Center</b> <b>6/10/59</b> <b>National Institutes of Health</b> <b>Bethesda 14, Maryland</b>			
ACTUAL SIGNATURE <b>Arthur T. Teplitzky</b> M.D.		PHYSICIAN'S NAME (Type) <b>Arthur T. Teplitzky, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>6-12-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. 15, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Spring Byers</b> ADDRESS <b>500 Pk. Heights Ave</b> <b>Balto 15, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 12 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





7030

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN 1b <u>8 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10617 ORDWAY DRIVE</u>				d. STREET ADDRESS <u>10617 ORDWAY DRIVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>IRENE</u> Last <u>STEVENSON</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>25</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 21, 1905</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HO'S WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>IOWA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>WM. A. SEWELL</u>				14. MOTHER'S MAIDEN NAME <u>EDNA WILLIAMSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Name <u>DAVE STEVENSON</u> Address <u>AS ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PARKINSON DISEASE</u> <u>350X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JAN.</u> , 19 <u>59</u> , to <u>JUNE 25, 1959</u> , that I last saw the deceased alive on <u>JUNE 25</u> , 19 <u>59</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>SILVER SPRING, MD.</u> DATE SIGNED <u>6/25/59</u>							
ACTUAL SIGNATURE <u>James A. Roberts</u> M.D. <u>8907 GEORGIA AVENUE</u>				DATE SIGNED <u>6/25/59</u>			
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				ADDRESS <u>SILVER SPRING, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>6/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Humphrey, Inc.</u> <u>Raymond A. Ziska</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 29 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from the register prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7031

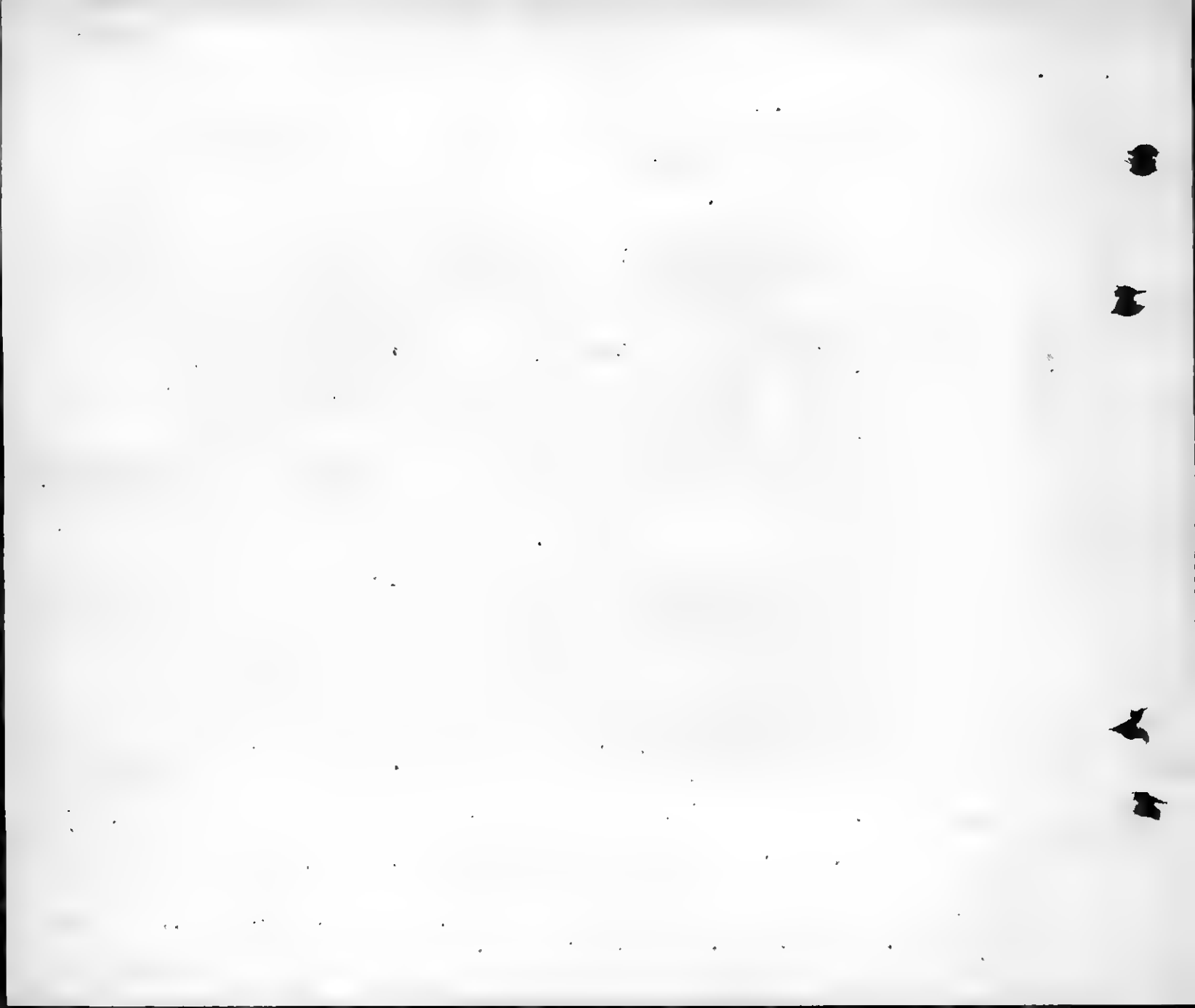
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

07017

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN Ib <u>8 1/2 YEARS</u>		d. STREET ADDRESS <u>19714 DILSTON ROAD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>19714 DILSTON ROAD</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>CLARENCE</u> Last <u>STORM</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1916</u>
9. AGE (In years last birthday) <u>43 yrs.</u>		IF UNDER 1 YEAR Months <u>43</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GAS SERVICE MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GAS Company</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME (By ADOPTION) <u>STORM, FRANK</u>	
14. MOTHER'S MAIDEN NAME (By ADOPTION) <u>STOTT</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>577 16 1188</u>		INFORMANT <u>MRS. CHAS. STORM</u> Address <u>AS ABOVE</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>CORONARY OCCLUSION</u> (c) <u>CORONARY ATHEROSCLEROSIS</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>3 MONTHS</u> <u>6 MONTHS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>FEB. 27</u> , 1959, to <u>JUNE 7</u> , 1959, that I lost the deceased alive on <u>JUNE 7</u> , 1959, and that death occurred at <u>7:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James A. Roberts</u>		ADDRESS (Street, city or town, state) <u>8107 GEORGIA AVENUE</u> DATE SIGNED <u>JUNE 7, 1959</u>	
PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>		<u>SILVER SPRING, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/10/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Prince George Co., Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>



6892

## CERTIFICATE OF DEATH

07018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>2 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>514 Tulip Ave</i>				d. STREET ADDRESS <i>514 Tulip Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>BURDETTE FRANKLIN SWAN</i> First Middle Last				4. DATE OF DEATH Month <i>6</i> Day <i>4</i> Year <i>1959</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4/8/1876</i>	9. AGE (In years last birthday) <i>83</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>upholsterer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>upholstering</i>		11. BIRTHPLACE (State or foreign country) <i>Michigan</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Franklin W. Swan</i>				14. MOTHER'S MAIDEN NAME <i>Huff</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>579-44-3511</i>		17. INFORMANT Address <i>Mr. J. F. Harrison, 514 Tulip Ave, Takoma Park</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Terminal bronchopneumonia</i> <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Malnutrition</i> DUE TO (c) <i>generalized arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Today</i> <i>2 months</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <i>April 17, 1959</i> , to <i>June 4, 1959</i> , that I last saw the deceased alive on <i>June 4, 1959</i> , and that death occurred at <i>10:40 A.M.</i> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <i>918 University Blvd. E., Silver Spring, Md.</i>				DATE SIGNED <i>6/4/59</i>			
ACTUAL SIGNATURE <i>Enio Maggi</i>				M.D. <i>Silver Spring, Md.</i>			
PHYSICIAN'S NAME (Type) <i>ENIO MAGGI</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>June 6, 1959</i>		22c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>		22d. LOCATION (City, town or county) (State) <i>Prince George's County, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Arthur Walters, 254 Carroll St. NW, DC.</i>				24a. REC'D BY REGISTRAR DATE <i>JUN 8 '59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



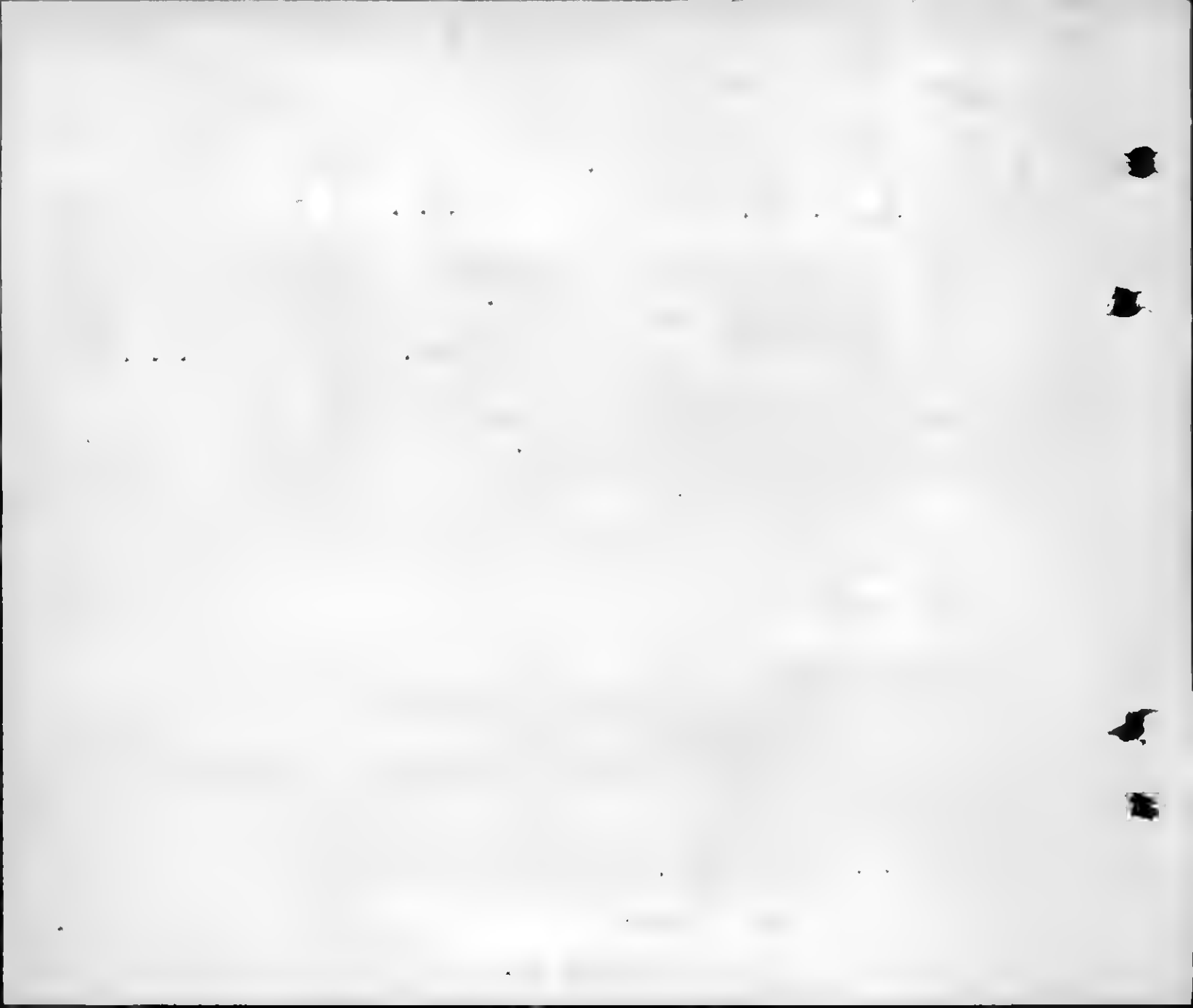
7032

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>8 Hr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Montgomery Co. Gen. Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma Jane Taylor</b>		4. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 4 1881</b>
9. AGE (In years last birthday) <b>77</b> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mass.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Schofield</b>		14. MOTHER'S MAIDEN NAME <b>Harriet Lee</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Ulysses Griffith</b>		Address <b>Same as 2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>475X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute upper respiratory infection</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized arteriosclerosis, bronchiectasis, hypertension</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 hours</b> <b>1 2 to 15 hr</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1956, to June 19, 1959</b> , that I last saw the deceased alive on <b>June 19, 1959</b> , and that death occurred at <b>12:31 PM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>Main Street</b> DATE SIGNED <b>6/19/59</b>			
ACTUAL SIGNATURE <b>G. F. Meadors</b> M.D.		PHYSICIAN'S NAME (Type) <b>G. F. Meadors, M.D.</b> <b>Damascus, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>June 22</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dunmore</b>	22d. LOCATION (City, town, or county) (State) <b>Scranton Penn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy W. Barber</b> ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.





6893

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington San + Hospt.</u>				e. STREET ADDRESS <u>1 Moxley Rd</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Albert</u> Last <u>Tenly</u>				4. DATE OF DEATH Month <u>June</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/9/91</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Albert Tenly</u>				14. MOTHER'S MAIDEN NAME <u>Schaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.I.</u>				16. SOCIAL SECURITY NO <u>579-05-1645</u>		17. INFORMANT <u>Mrs. Ada L. Tenly, same as #2</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>Myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Chronic glomerulonephritis</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>6/15, 1959</u> , to <u>6/20, 1959</u> , that I last saw the deceased alive on <u>6/19, 1959</u> , and that death occurred at <u>12:15 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Dean H. Hardink</u> M.D. <u>113 Christie St. NW, Wash. D.C. 6/2/59</u> PHYSICIAN'S NAME (Type) <u>DEAN H. HARDINK</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 23 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Prince George's County, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Walters</u> ADDRESS <u>234 Carroll Rd NW DC</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 22 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

7033

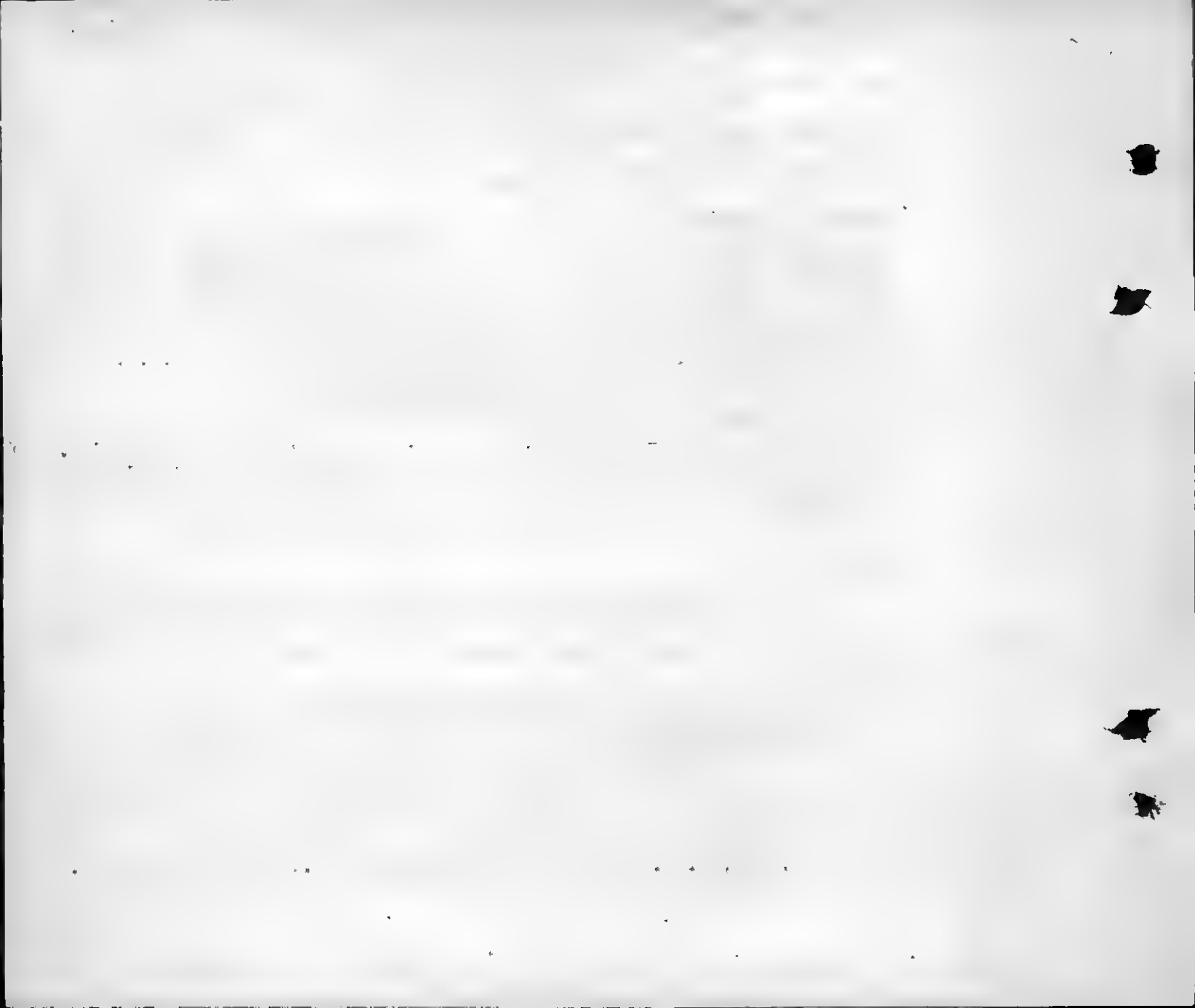
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07021

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>19 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9925 Markham Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>Enoch</b> Last <b>Thompson</b>		4. DATE OF DEATH Month <b>June</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/89</b>
9. AGE (In years last birthday) yrs <b>69</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wash. Post Newspaper</b>	
11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Thompson</b>		14. MOTHER'S MAIDEN NAME <b>EMILY WILDERMUTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>161-10-4150</b>	
17. INFORMANT <b>Mrs. Margie G. Thompson, 9925 Markham St. Silver Spring, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial infarct (old)</b> DUE TO (c) <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>6-7 mo</b> <b>?</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1947</b> to <b>23 June, 1957</b> , that I last saw the deceased alive on <b>21 June, 1957</b> , and that death occurred at <b>11:40 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>William D. Aud</b> M.D.		22. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumperkey, Inc.</b>	
PHYSICIAN'S NAME (Type) <b>William D. Aud, M. D.</b>		23. ADDRESS <b>9006 Colesville Rd., Silver Spring, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>TRANS. &amp; BURIAL</b>		22b. DATE THEREOF <b>6/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Vernon Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Philadelphia, Pennsylvania</b>	
24a. REC'D BY REGISTRAR <b>DATE JUN 25 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



7034

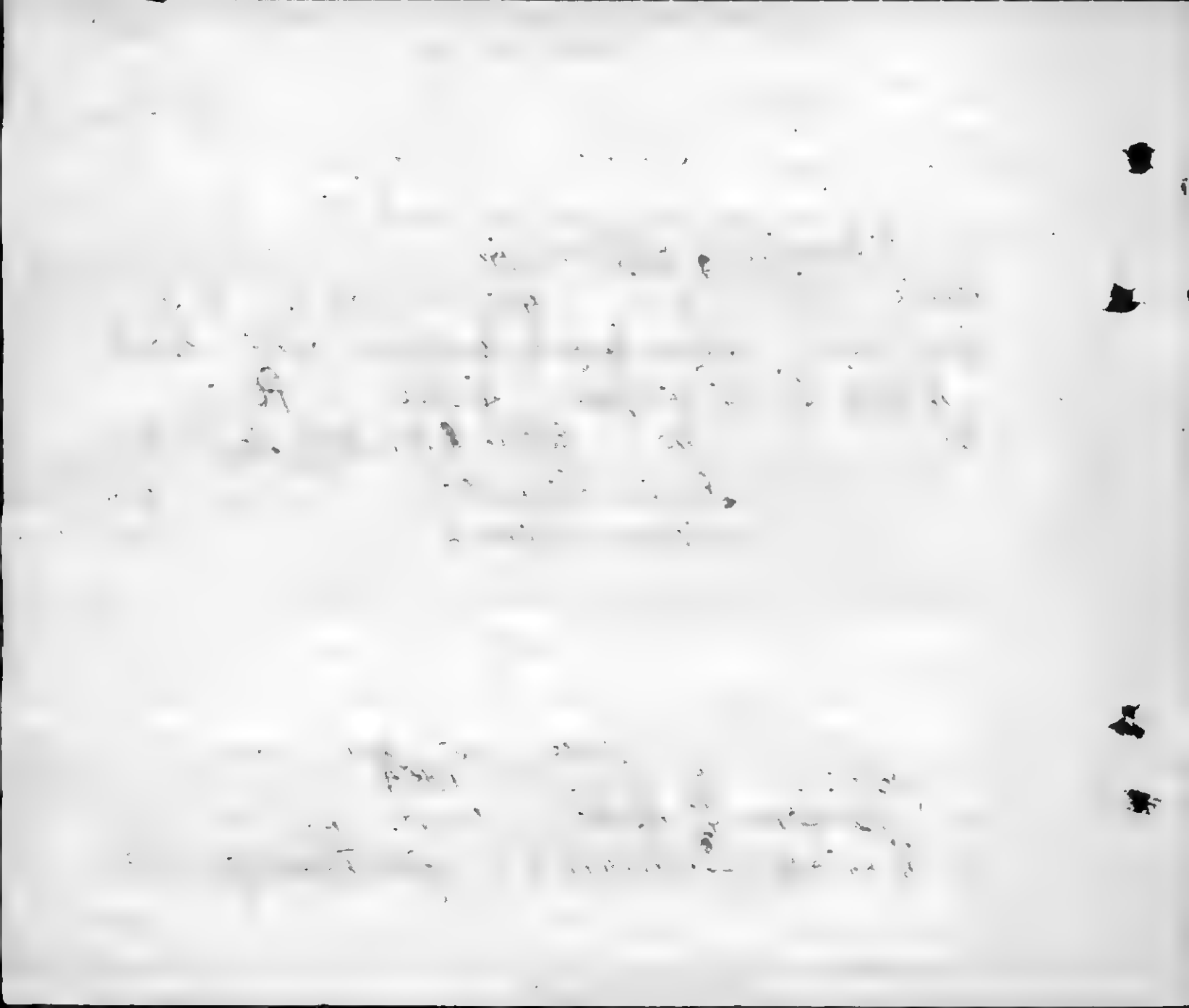
CERTIFICATE OF DEATH

07022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <i>Rural, Boyd</i>		c. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town) <i>Boyd</i>	
c. LENGTH OF STAY IN 1b <i>5 years</i>		d. STREET ADDRESS <i>Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>L</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Thompson, Elizabeth Ann</i>		4. DATE OF DEATH Month <i>June</i> Day <i>4</i> Year <i>1959</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug - 30 - 1882</i>
9. AGE (In years, last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>9</i> Days <i>15</i> Hours <i>3</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home keeping</i>	
11. BIRTHPLACE (State or foreign country) <i>Montgomery Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William C. Crawford</i>		14. MOTHER'S MAIDEN NAME <i>Della - Ray</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>No.</i>	
17. INFORMANT <i>Eleanor E. B. King, Boyd, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Senile Dementia</i> 4-20-59 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <i>Arterio-sclerosis</i> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <i>4-5 years</i> <i>4-10 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Rice</i> , 1955, to <i>June - 4 - 1959</i> , that I last saw the deceased alive on <i>June - 2 - 1959</i> , and that death occurred at <i>11:45 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>William E. Miller</i> M.D.		ADDRESS (Street, city or town, state) <i>7 - Brooke ave., Gaithersburg, Md</i>	
PHYSICIAN'S NAME (Type) <i>William C. MILLER</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>	22b. DATE THEREOF <i>6-6-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Gaithersburg, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. E. Miller</i>		24a. REC'D BY REGISTRAR <i>Arthur E. Harris</i>	
ADDRESS <i>316 E. Diamond Ave Gaithersburg, Md</i>		DATE <i>JUN 9 '59</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7035

CERTIFICATE OF DEATH

07023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>D.C.</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Resnor Sanitarium-5721 Grosvenor here</u>				d. STREET ADDRESS <u>1324 Forragut St. N.W.</u>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Scott</u> Last <u>Tipton</u>				4. DATE OF DEATH Month <u>June</u> Day <u>29</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 4, 1878</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Alfred White</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alice Downing</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Laughton - Mrs. Virginia Phelps - 6504 W. Washington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 29, 1957</u> , to <u>June 29, 1959</u> , that I last saw the deceased alive on <u>June 29, 1959</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert Young</u> M.D.				ADDRESS (Street, city or town, state) <u>2500 Calver St. N.W. Washington 8, D.C.</u>			
DATE SIGNED <u>6/30/59</u>				PHYSICIAN'S NAME (Type) <u>Robert Young</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>7/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek</u>		22d. LOCATION (City, town, or county) (State) <u>Washington, D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Lawrence Davis Inc., 1756 Pa. Ave. N.E.</u>				24a. REC'D BY REGISTRAR <u>JUL 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital by the attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

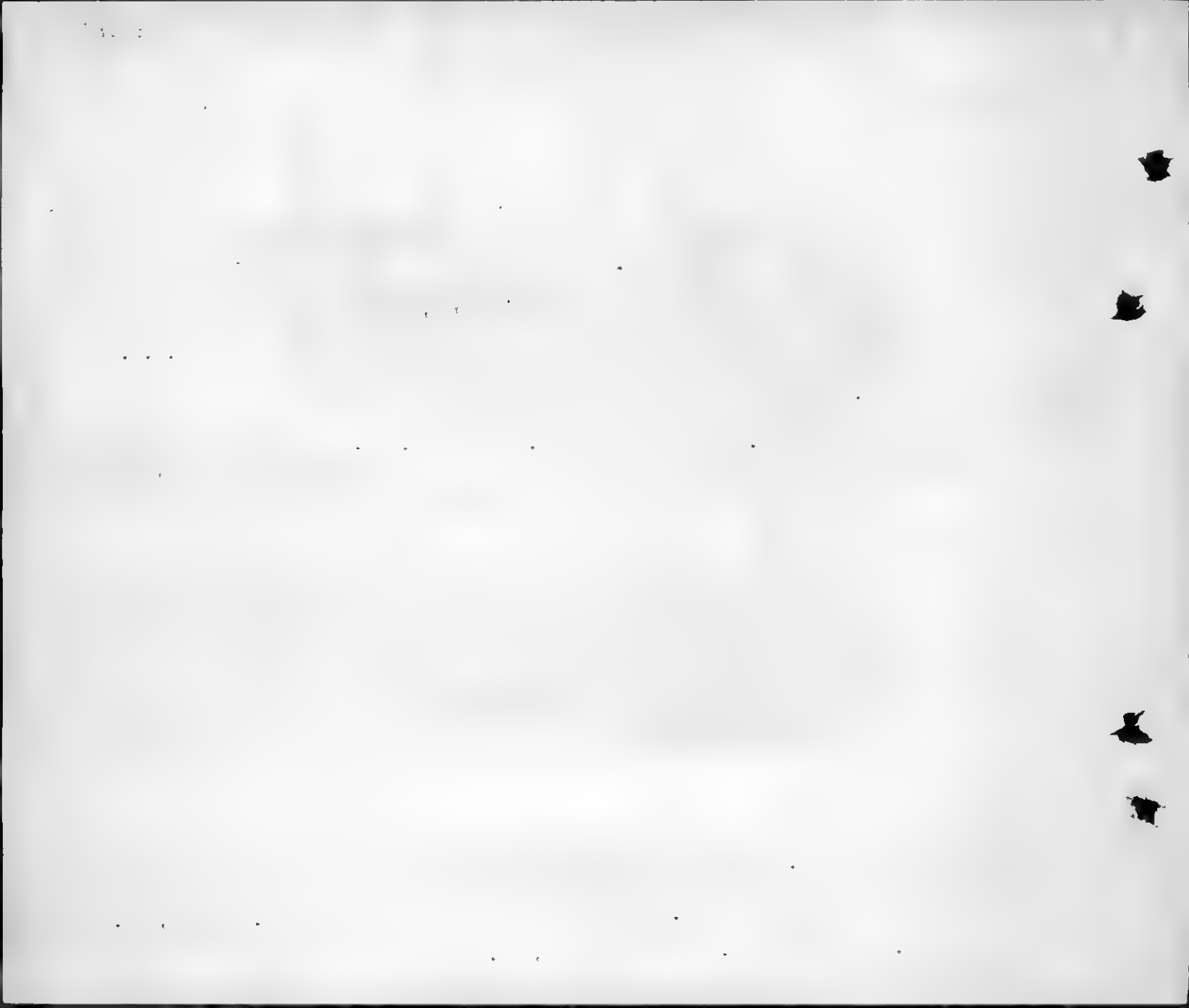
7036

## CERTIFICATE OF DEATH

07024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>56 Silver Spring</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kensington Gardens Rest Home</u>		d. STREET ADDRESS <u>2324 Seminary Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frederick</u> First <u>J. Trumpour</u> Middle Last		4. DATE OF DEATH Month <u>June</u> Day <u>17th</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCTOBER 3, 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick W. Trumpour</u>		14. MOTHER'S MAIDEN NAME <u>Laura Machey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> <u>Spanish Amer.</u>		16. SOCIAL SECURITY NO	
17. INFORMANT Address <u>Mrs. William Davis, 2700 Southington Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Artery Thrombosis</u> <u>332X</u> DUE TO <u>Shaker Heights, Ohio</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Artery Sclerosis</u> <u>3 yrs</u> (c) <u>Generalized Arteriosclerosis</u> <u>15 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate; Pneumonia 10 days ago</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> to <u>17 June, 1959</u> , that I last saw the deceased alive on <u>14 June, 1959</u> , and that death occurred at <u>1:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Merton L. White</u> M.D. <u>11134 Georgia Ave Silver Spring, Md</u>		DATE SIGNED <u>17 June 59</u>	
PHYSICIAN'S NAME (Type) <u>Merton L. White</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>6/18/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>FT. LINCOLN CREMATORY</u>		22d. LOCATION (City, town, or county) (State) <u>PRINCE GEO. COUNTY, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		ADDRESS <u>SILVER SPRING, MD.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 23 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

6894

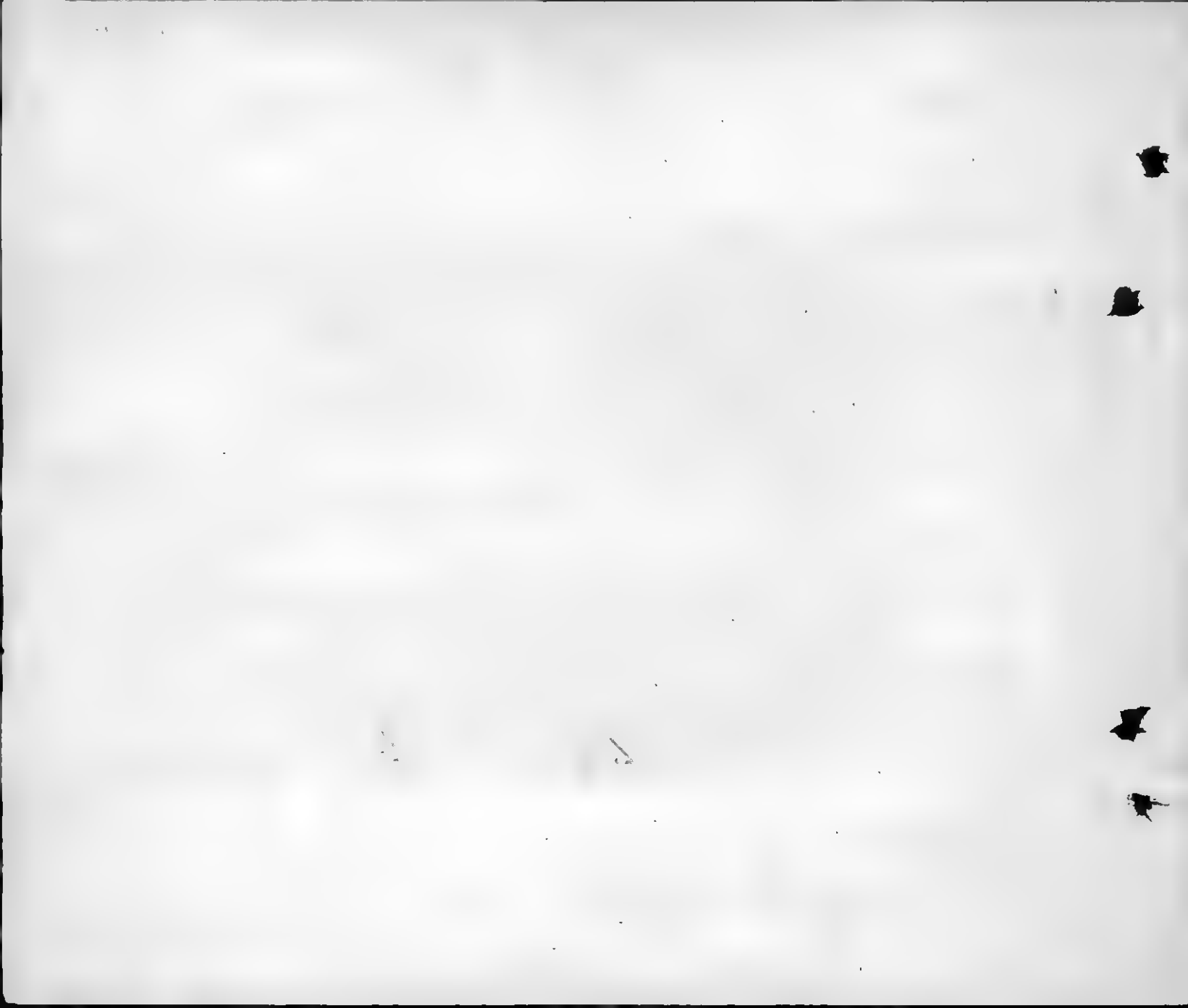
## CERTIFICATE OF DEATH

07025

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u>		2. USUAL RESIDENCE (Where deceased lived) If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>1305 Merriman Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Jacob</u> Middle <u>(NMN)</u> Last <u>Turetsky</u>		4. DATE OF DEATH Month <u>June</u> Day <u>7</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Jewish</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-14-85</u>
9. AGE (In years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR Months Days Hours Min	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Luggage worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Russia</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Abraham Turetsky</u>		14. MOTHER'S MAIDEN NAME <u>ROSE SCHISMAN?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>San. Raymond Turetsky - as above</u>	
17. INFORMANT Address <u>same</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>CORONARY THROMBOSIS</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SEVERE RHEUMATOID ARTHRITIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 HR</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/6</u> 19 <u>59</u> to <u>6/7</u> 19 <u>59</u> that I last saw the deceased alive on <u>7/6</u> 19 <u>59</u> and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u>		PHYSICIAN'S NAME (Type) <u>[Signature]</u>	
22a. (BURIAL) CREMATION, REMOVAL (Specify) <u>June 9, 1959</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>United Hebrew Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Station Island N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>B. H. Wanzan</u>		ADDRESS <u>3501-14th St. NW</u>	
24a. REC'D BY REGISTRAR <u>June 9 1959</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained in the hospital or by the attending physician. After the certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



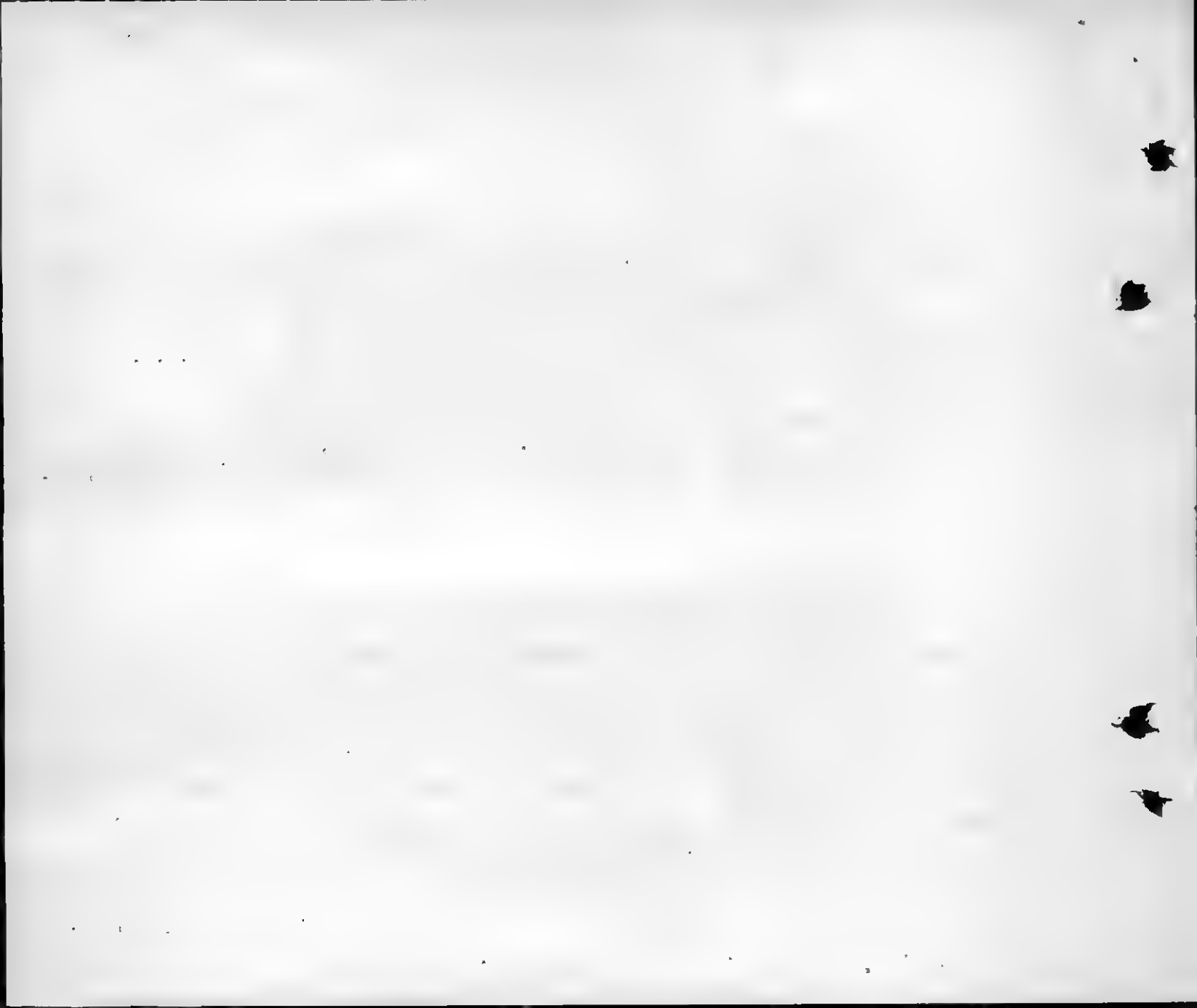
7037

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN 1b <u>75 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1300 HARDING LANE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PEARLE</u> Middle <u>N.</u> Last <u>TURNER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/18/84</u>
9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>19</u> Hours <u>59</u> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH HARDING</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE REYNOLDS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Sterling Turner, 1304 Harding Lane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>TERMINAL GASTRIC CA. +</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>GENERALIZED METASTASIS</u> DUE TO (c)		19. ONSET AND DEATH <u>Silver Spring, Md.</u> <u>5 YRS</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 JAN</u> , 19 <u>55</u> , to <u>5 JUNE</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>2 JUNE</u> , 19 <u>59</u> , and that death occurred at <u>4:00 AM</u> , from the causes and on the date stated above			
ACTUAL SIGNATURE <u>John Bosley Ziegler</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>OLNEY, MD. JUNE 59</u>	
PHYSICIAN'S NAME (Type) <u>JOHN BOSLEY ZIEGLER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6/8/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HARDING ESTATE FAMILY CEMETERY, MONTGOMERY COUNTY, MD.</u>	
22d. LOCATION (City, town, or county) (State) <u>MONTGOMERY COUNTY, MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>WARNER E. PUMPHREY, INC.</u> <u>Raymond A. Ziska</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 9 '59</u>	
ADDRESS <u>SILVER SPRING, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7038

## CERTIFICATE OF DEATH

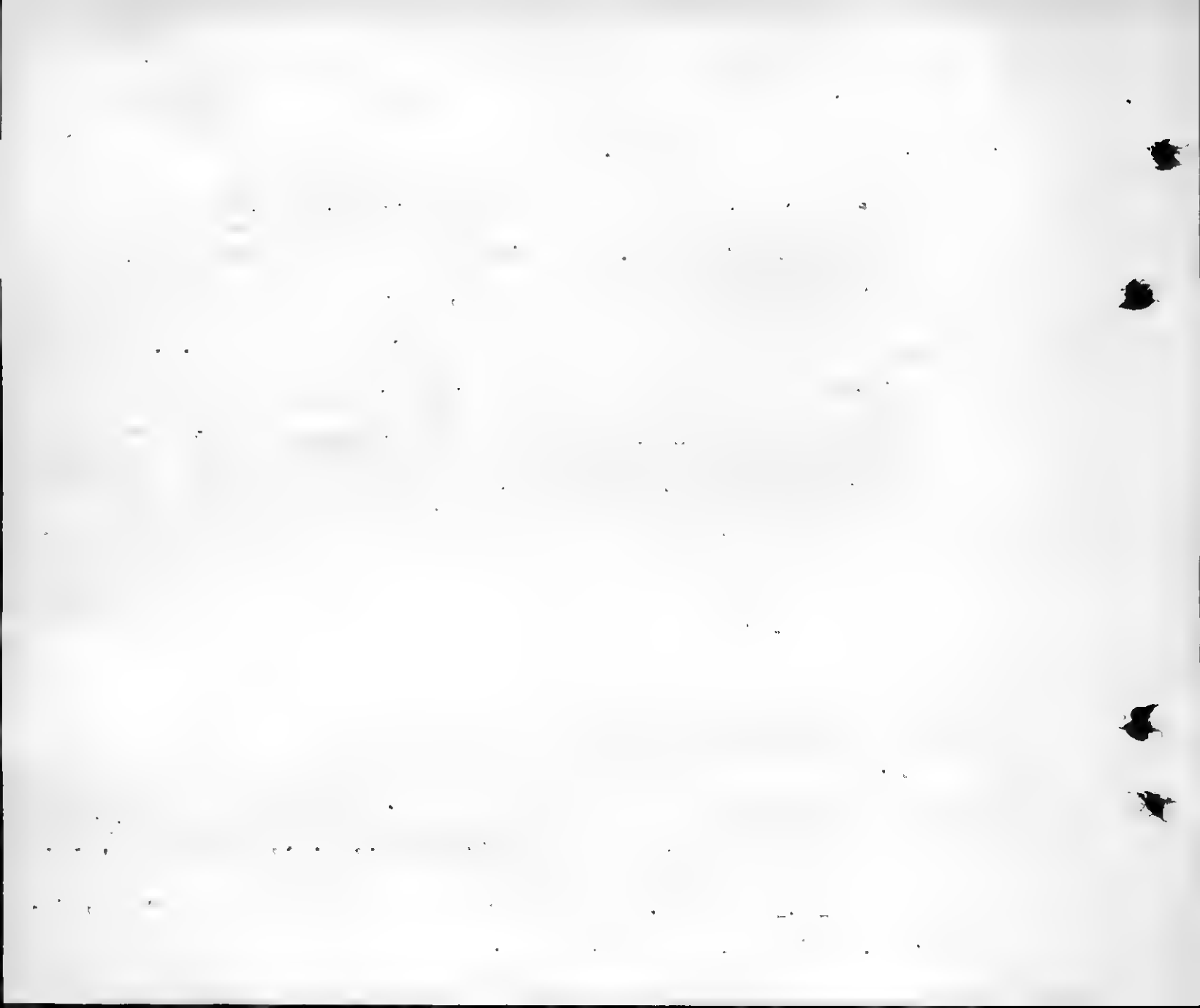
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> c. LENGTH OF STAY IN 1b <b>7 yrs.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>4226 East-West Highway</b>		2. USUAL RESIDENCE (Where deceased lived If institut on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> d. STREET ADDRESS <b>4226 East-West Highway</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RICHARD</b> Middle <b>E.</b> Last <b>WENZEL</b>		4. DATE OF DEATH Month <b>June</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1888</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>28</b> Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.-Naturalize</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>579-34-3566</b>	
17. INFORMANT <b>Wife</b>		Address <b>Same as Item#2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peripheral vascular failure</b> DUE TO (b) <b>Dermatomyositis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>Bronchectasis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b> <b>1 1/2 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchectasis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb.</b> , 19 <b>58</b> , to <b>June</b> , 19 <b>59</b> (that I last saw the deceased alive on <b>24 June</b> , 19 <b>59</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George W. Reeves</b>		DATE SIGNED <b>1746 - K St. N.W. Washington</b>	
PHYSICIAN'S NAME (Type) <b>GEORGE W. REEVES</b>		M.D. <b>1746 - K St. N.W. Washington</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-29-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Prince George County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY,</b>		ADDRESS <b>Bethesda, Md.</b>	
24a. REC'D BY REGISTRAR <b>JUN 29 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

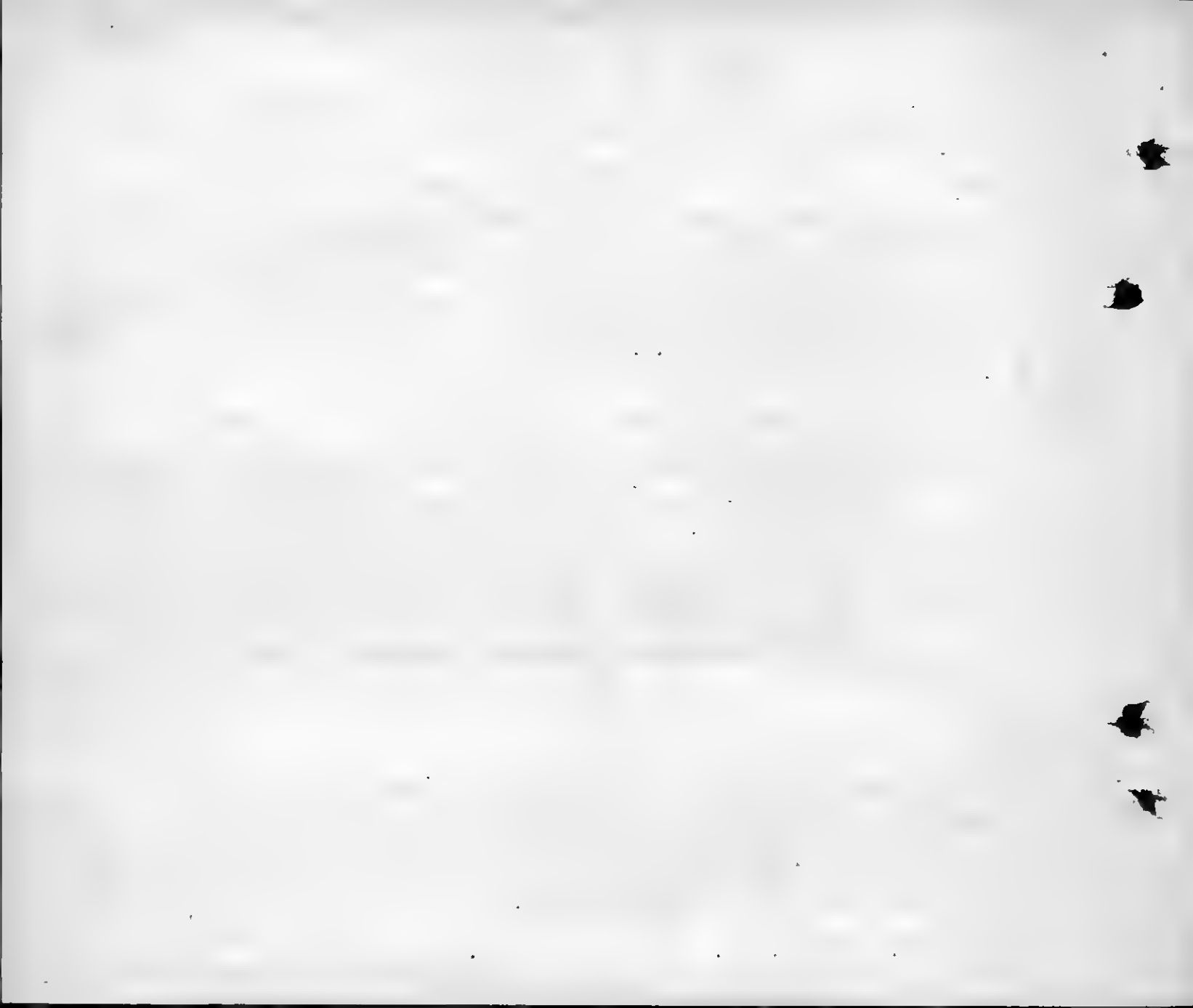
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58





Reg. Dist. No.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After it is signed by the attending physician and completed, this certificate has been signed by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7039

## CERTIFICATE OF DEATH

07029

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>RESMOR SANITARIUM</u> <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>WASH. D.C.</u> b. COUNTY <u>3122 LYNDAL PL. S.E. WASH. D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WASH. D.C.</u> 47X-3	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>2 wks</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RESMOR SANITARIUM</u>		d. STREET ADDRESS <u>3122 LYNDAL PL. S.E.</u>	
3. NAME OF DECEASED (Type or print) <u>Patrick J. White</u>		4. DATE OF DEATH <u>JUNE 18, 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 7, 1875</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>REAL ESTATE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AGENT</u>	
11. BIRTHPLACE (State or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>EDWARD WHITE</u>		14. MOTHER'S MAIDEN NAME <u>JOHANNA CONNORS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>YES-UNKNOWN</u>	
17. INFORMANT <u>ANNABELLE HARTMAN</u>		Address <u>PITTSBURG, MD.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF PROSTATE WITH METASTASES</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary Artery Heart Disease; Mild Diabetes.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 15, 1959</u> to <u>June 18, 1959</u> that I last saw the deceased alive on <u>June 17, 1959</u> , and that death occurred at <u>6:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertram F. Schaefer</u> M.D. <u>1780 MASS. AVE. N.W. WASH. D.C.</u>		ADDRESS (Street, city or town, state) <u>WASH. D.C.</u> DATE SIGNED <u>June 18, 1959</u>	
PHYSICIAN'S NAME (Type) <u>BERTAM F. SCHAEFER</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>6-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVET</u>	22d. LOCATION (City, town, or county) (State) <u>WASH. D.C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>17324 T. Ryan</u> ADDRESS <u>317 Penna</u>		24a. REC'D BY REGISTRAR <u>JUN 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>



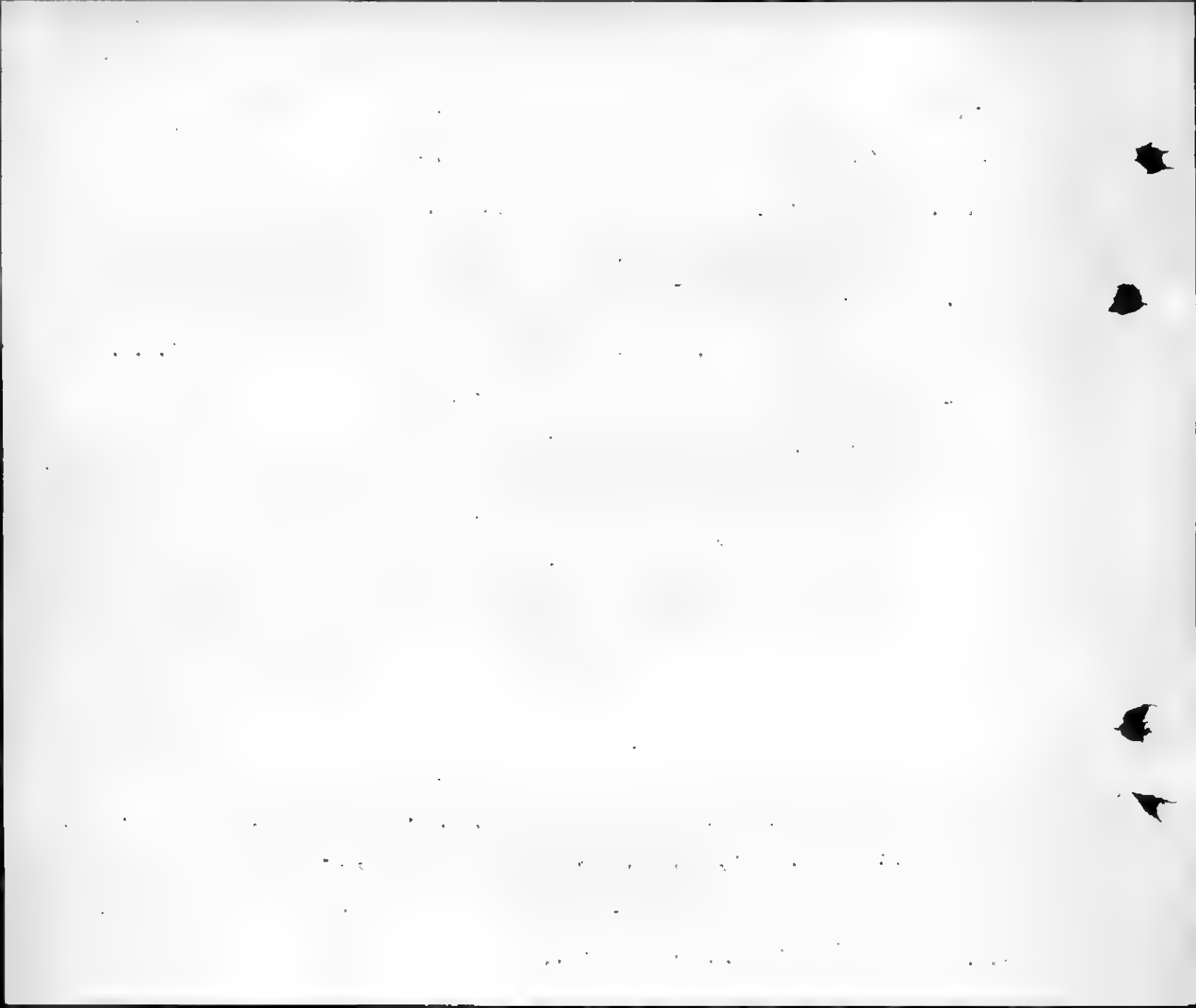
CERTIFICATE OF DEATH

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) b. STATE <b>Virginia</b> <b>COUNTY</b> <b>Arlington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>				c. LENGTH OF STAY IN 1b <b>75 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>				e. STREET ADDRESS <b>4334 N. Fairfax Drive</b>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Edward</b> Last <b>WHITELEY</b>				4. DATE OF DEATH Month <b>June</b> Day <b>26</b> Year <b>19 59</b>			
5 SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-28-85</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mariner</b>
10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>			11. BIRTHPLACE (State or foreign country) <b>South Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Winfield WHITELEY</b>				14. MOTHER'S MAIDEN NAME <b>Nancy HAWKINS</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WWI&amp;II, Korean 579-52-3277</b>		INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 330X DUE TO <b>generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Chronic Pulmonary Emphysema</b> 18.2						INTERVAL BETWEEN ONSET AND DEATH <b>24-36 hrs</b> <b>Chronic</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 12</b> , 19 <b>59</b> , to <b>June 26</b> , 19 <b>59</b> that I last saw the deceased alive on <b>June 26</b> , 19 <b>59</b> , and that death occurred at <b>1:55 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>U. S. Naval Hospital, NNMC</b> DATE SIGNED <b>6-26-59</b> ACTUAL SIGNATURE <b>Jerome A. Gold</b> M.D. PHYSICIAN'S NAME (Type) <b>Jerome A. GOLD, LT, MC, USN</b> <b>Bethesda 14, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>6-30-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.W. Chambers Funeral Home, 517 11th St., SE</b>				24a. REC'D BY REGISTRAR DATE <b>JUN 30 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## 7041 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

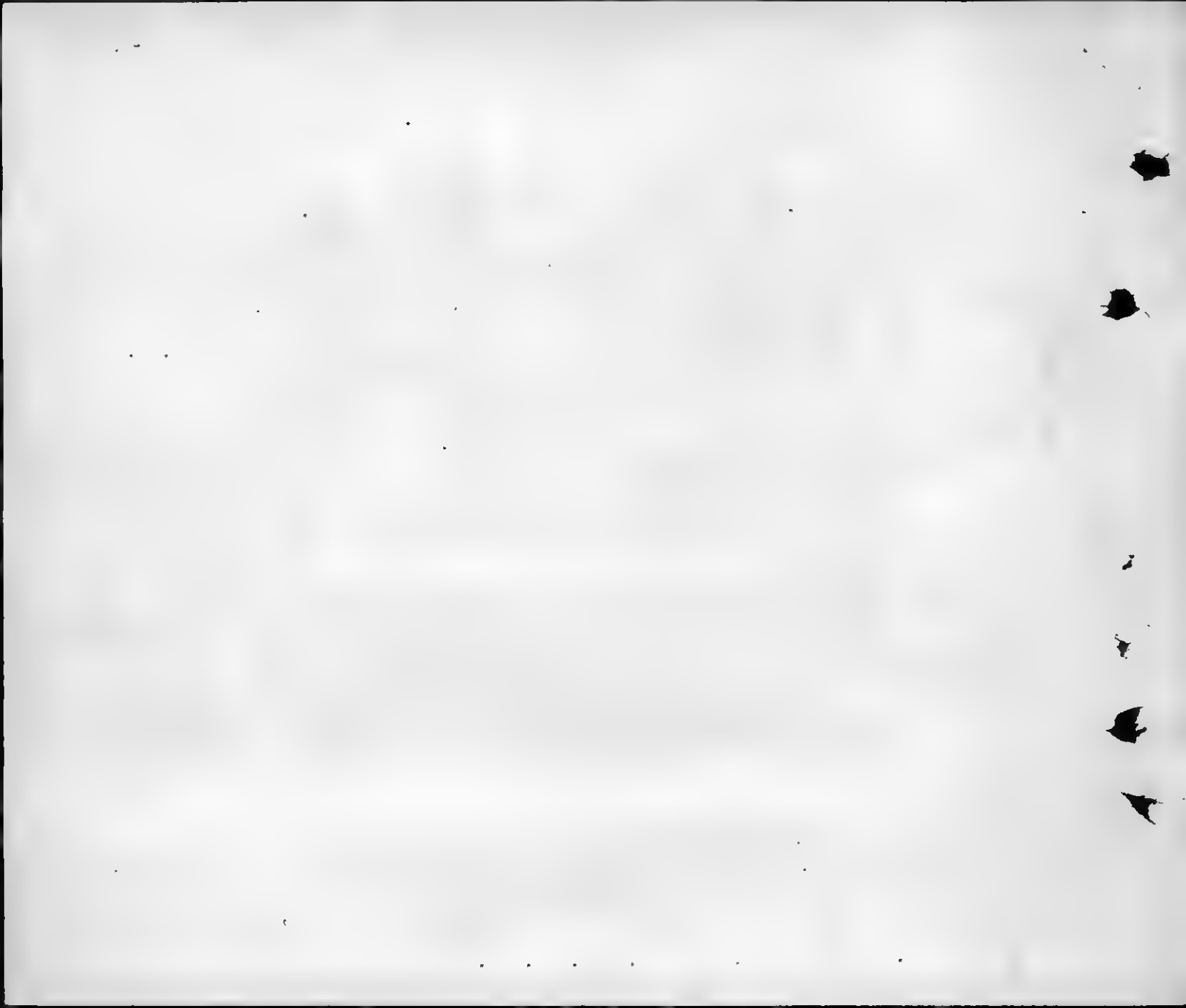
Items 4, 22c &amp; 22d Fill in 3-244 6/19/59.c.

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>15 years</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		d. STREET ADDRESS <b>225 Granville Dr.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Warner F. Wilckens</b>		4. DATE OF DEATH <b>June 13 1959</b>		5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1896</b>		9. AGE (In years last birthday) <b>62 yrs.</b>		IF UNDER 1 YEAR: Months <b>6</b> Days <b>13</b> Hours <b>19</b> Min. <b>59</b>							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waiter--Statler Hotel</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.							
17. INFORMANT <b>Warner H. Wilckens</b>		Address <b>RFD # 3 Seaford, Delaware</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Found dead in bed</b> (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Had been dead several days when found</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE <b>Frank J. Broschart</b>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>6-13-59</b>		EXAMINER'S NAME (Type) <b>FRANK J. BROSCHART</b>									
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>June 16th</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Seaford, Delaware</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Pumprey Inc.</b>		ADDRESS <b>8434 Ga. Ave. SS. Md.</b>		24a. REC'D BY REGISTRAR <b>JUN 16 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton &amp; House</b>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, write the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 should be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





Weight - 24 1/2 lbs.

## 704 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Suburban Hospital</u>				d. STREET ADDRESS <u>133 Moore Drive</u>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>GIRL</u> Middle <u>WILLIAMS</u> Last				4. DATE OF DEATH <u>JUNE 17</u> Year <u>1959</u> Month <u>JUNE</u> Day <u>17</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 17 1959</u>	
9. AGE (In years last birthday) yrs. <u>48</u>		IF UNDER 1 YEAR Months <u>48</u> Days <u>48</u> Hours <u>48</u> Min. <u>48</u>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>EDWARD CALVIN WILLIAMS</u>				14. MOTHER'S MAIDEN NAME <u>ALICE VIRGINIA GREEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>MOTHER</u> Address <u>—</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intracranial Hemorrhage</u> <u>160.5</u> DUE TO <u>laceration, left leaf, tentorium cerebelli</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity fetal atelectasis, breech delivery</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour <u>—</u> o. m. <u>—</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u> (County) <u>—</u> (State) <u>—</u>							
21. I certify that I attended the deceased from <u>JUNE 17, 1959</u> to <u>JUNE 17, 1959</u> , that I last saw the deceased alive on <u>JUNE 17, 1959</u> , and that death occurred at <u>5:12</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James S. Stanton</u> M.D.				ADDRESS (Street, city or town, state) <u>809 Viers Mill Rd. Rockville, Md.</u> DATE SIGNED <u>—</u>			
PHYSICIAN'S NAME (Type) <u>JAMES S. STANTON MD</u>				<u>809 Viers Mill Rd. Rockville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>6/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park..</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 25 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



7043

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07033

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN TB <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cabin John</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>13 Carver Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Helen Elizebeth Williams</u>				4. DATE OF DEATH Month Day Year <u>June 6, 1959 19</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-11-1918</u>		9. AGE (in years last birthday) <u>40</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William L. Hayward</u>				14. MOTHER'S MAIDEN NAME <u>Nettie C. ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-20-2077</u>		17. INFORMANT <u>Theodore Williams (husband)</u> Address <u>Item 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lacerations of Heart and Great Vessels</u> DUE TO <u>Fractured Chest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Automobile Accident</u> (c) <u>Automobile Accident</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Just</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driver of auto which left highway &amp; struck tree</u>					
20c. TIME OF INJURY Month, Day, Year <u>1:55 p.m. 6/6/59 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>highway</u>		20f. (City or town) (County) (State) <u>Cabin John Montgomery Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Frank J. Broschart</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Frank J. Broschart</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/> <u>June 7, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Snowden</u>				ADDRESS <u>Rockville, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 9 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing "pending," in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



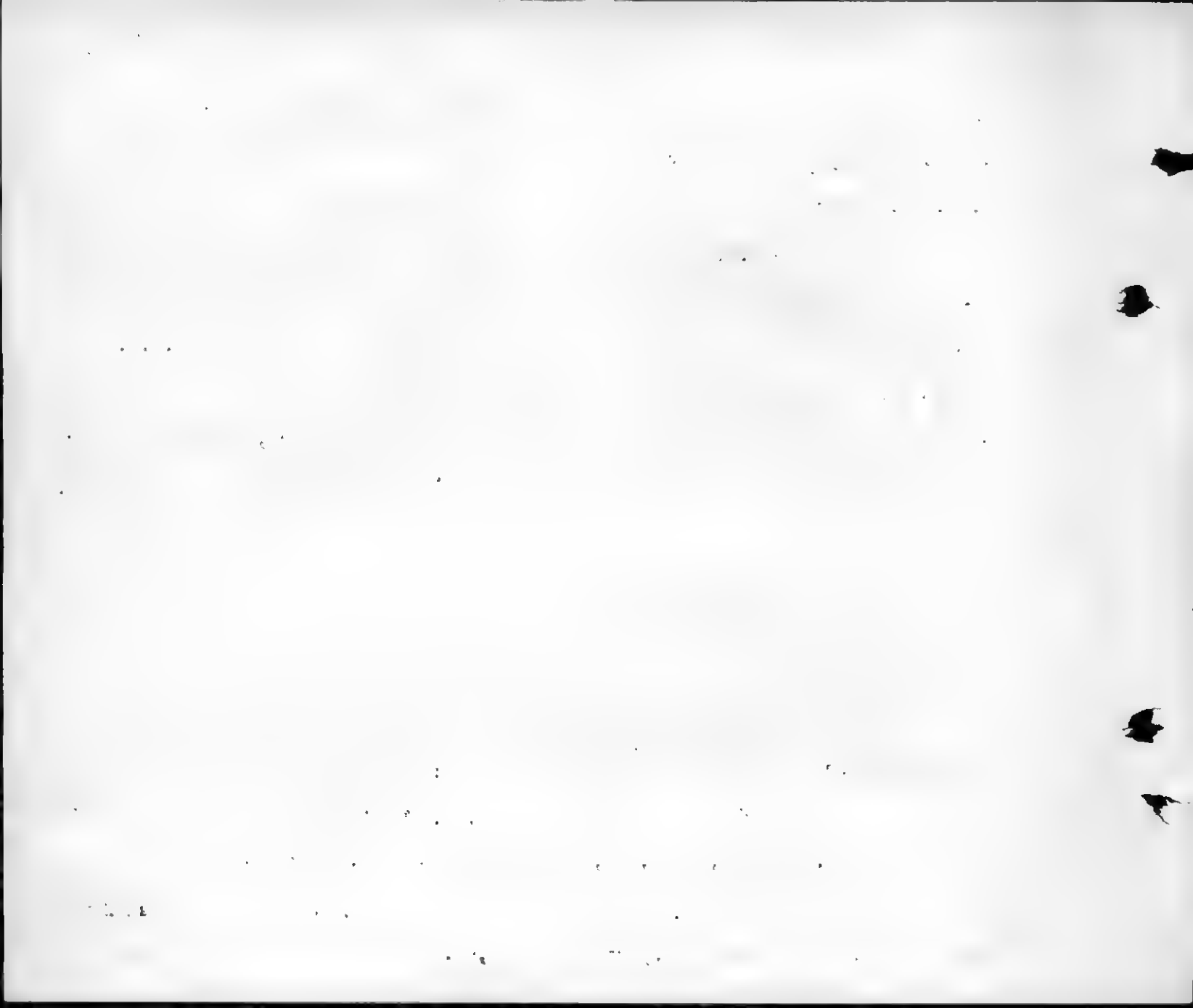
7044 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**CERTIFICATE OF DEATH**

07034

Reg. Dist. No. 215

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b> c. LENGTH OF STAY IN 1b <b>99 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>U. S. Naval Hospital</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <del>DELETED</del> <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>3515 Hillsmere Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Margaret WILSON</b>		4. DATE OF DEATH Month Day Year <b>June 20 1959</b>	
5 SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>4-14-01</b>
9. AGE (In years last birthday) <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - - - -	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert BAXTER</b>		14. MOTHER'S MAIDEN NAME <b>Margaret MUNN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
INFORMANT Address <b>(S) Major Alexander Wilson, USMC, same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon &amp; rectum</b> <b>153.8</b> DUE TO <b>metastases.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			INTERVAL BETWEEN ONSET AND DEATH <b>14 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>March 13</b> , 19 <b>59</b> , to <b>June 20</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>June 19</b> , 19 <b>59</b> , and that death occurred at <b>1:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Burt C. Johnson</b> M.D. <b>U. S. Naval Hospital</b> <b>6-20-59</b> PHYSICIAN'S NAME (Type) <b>Burt C. JOHNSON, LCDR, MC, USN</b> <b>Bethesda 14, Maryland</b>			
22a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial-Shipment</b>	22b. DATE THEREOF <b>6-22-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Whittier California</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Loring Byers</b> ADDRESS <b>8728 Liberty Rd., Randallstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JUN 23 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

7045

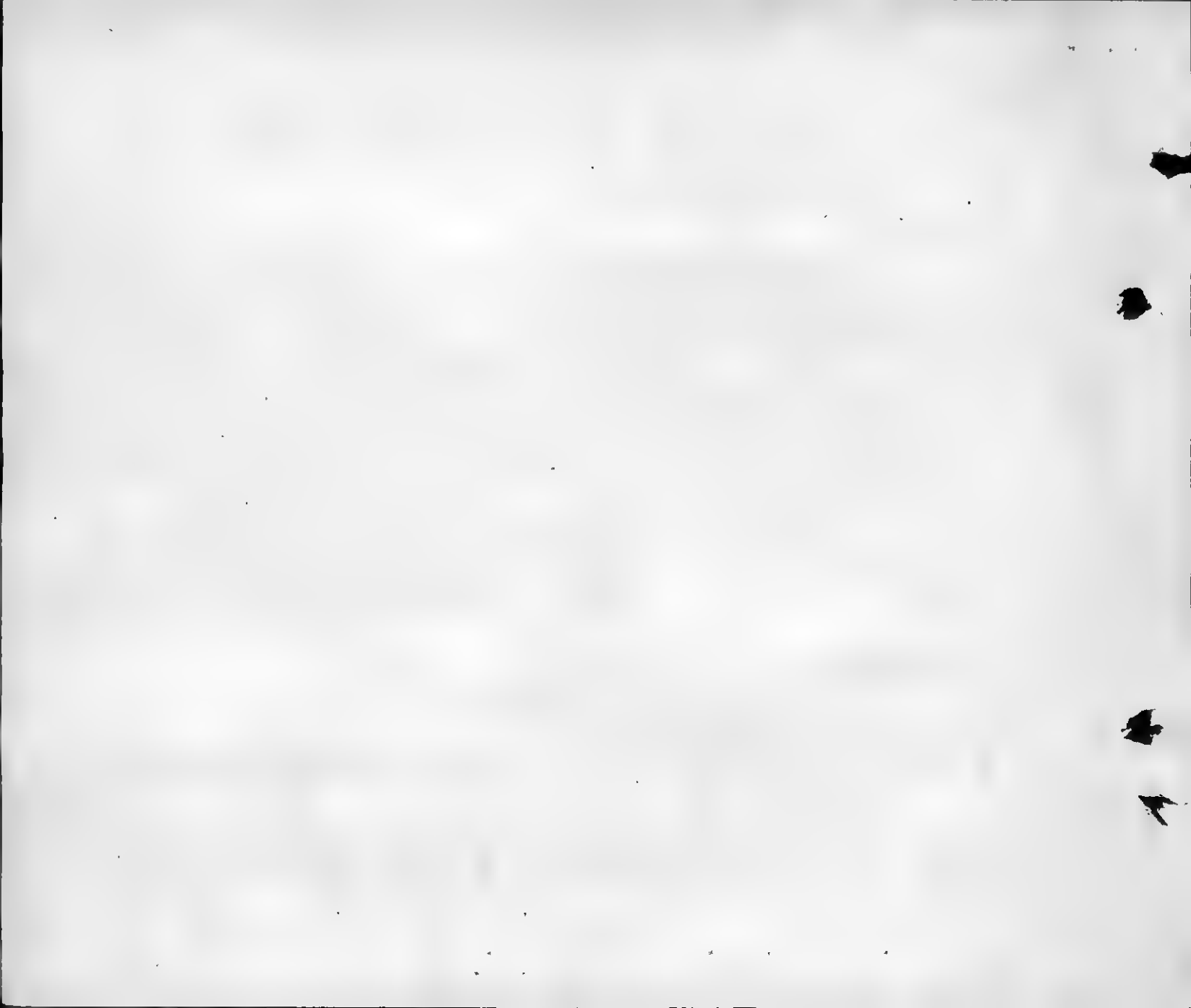
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07035

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Montg</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>4 yrs</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2012 Grosnell St</u>			d. STREET ADDRESS <u>2012 Grosnell St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Margaret Lane Wycoski</u>			4. DATE OF DEATH June 23 1959		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1923</u>		9. AGE (In years last birthday) <u>35</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John H Staples</u>			14. MOTHER'S MAIDEN NAME <u>Janet Marders</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>yes</u>	17. INFORMANT <u>Jan. Wycoski - Strum 2</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of cervix with metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 13 mo</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Frank J. Broschert</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-23-59</u>	
EXAMINER'S NAME (Type) <u>FRANK J. Broschert</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/26/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		22d. LOCATION (City, town, or county) <u>Arlington, Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Warner B. Pumphrey, Inc.</u>		ADDRESS <u>8434 Georgia Ave.</u>		24a. REC'D BY REGISTRAR <u>Raymond A. Ziska, mgr.</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



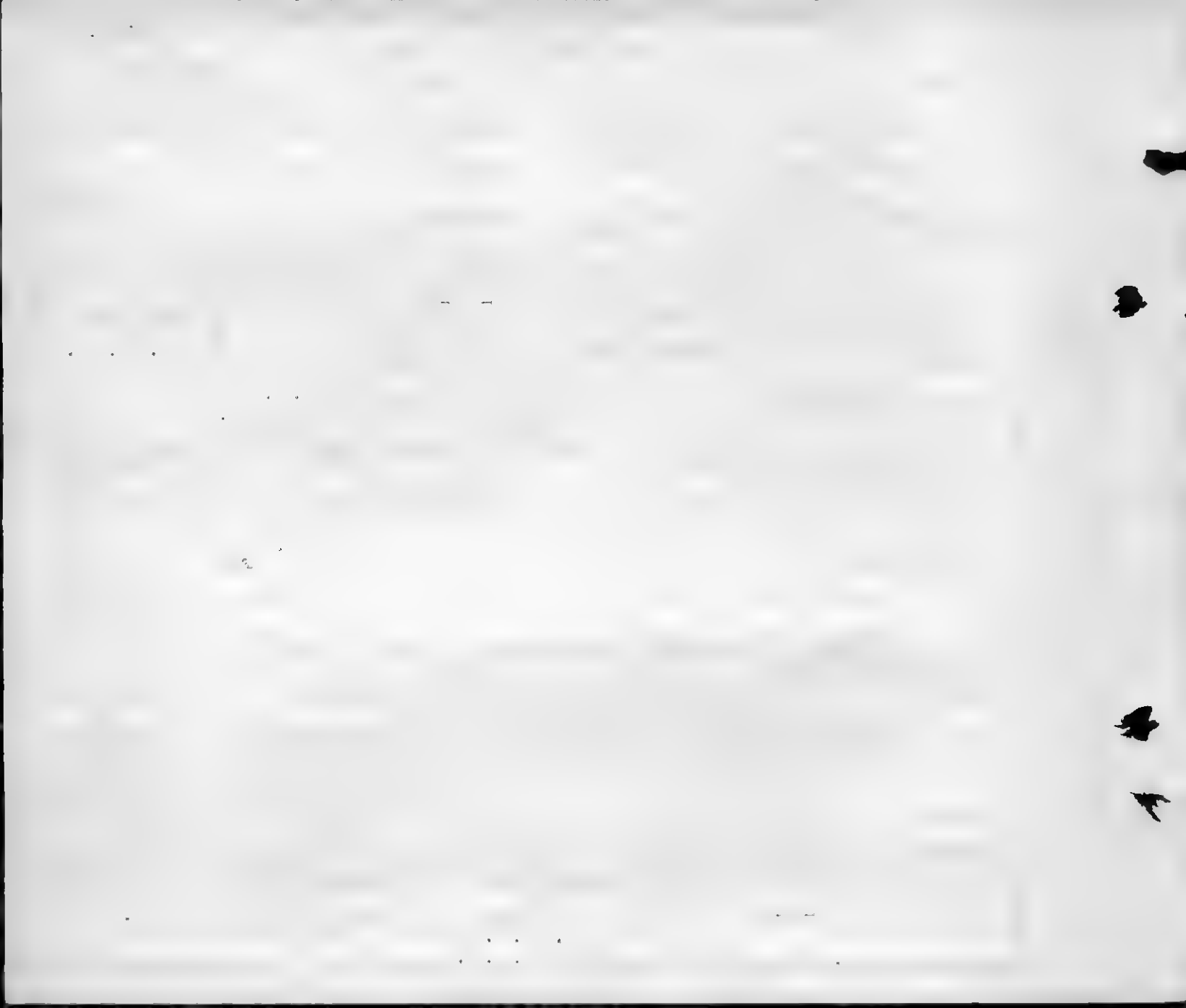


7046

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
c. LENGTH OF STAY IN 1b <b>6 MONTHS</b>		d. STREET ADDRESS <b>8804 BRADFORD ROAD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8804 BRADFORD ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANCES</b> Middle <b>ZANET</b> Last <b>ZANET</b>		4. DATE OF DEATH Month <b>6</b> Day <b>6</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-9-81</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DRESS MAKER</b>	
11. BIRTHPLACE (State or foreign country) <b>AUSTRIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>JOHN SAYEK</b>		14. MOTHER'S MAIDEN NAME <b>MARY --??--</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>MISS ESTELE LORRAINE (SAME AS #2)</b>	
17. INFORMANT <b>MISS ESTELE LORRAINE (SAME AS #2)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 44021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. ft.</b> p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8 May 1959</b> to <b>6 June 1959</b> , that I last saw the deceased alive on <b>6 June 1959</b> , and that death occurred at <b>8:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1011 UNIV. BLVD E SILVER SPRING</b> DATE SIGNED <b>2nd</b>			
ACTUAL SIGNATURE <b>Thomas P Fogarty</b> M.D.		PHYSICIAN'S NAME (Type) <b>THOMAS P FOGARTY</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>6-7-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>BEYONNE</b>		22d. LOCATION (City, town, or county) (State) <b>N. J.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Francis J. Collins</b> ADDRESS <b>WASH. D.C.</b>		24a. REC'D BY REGISTRAR <b>DATE JUN 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles E. Hume</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and coroner must fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7047

CERTIFICATE OF DEATH

07037

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>75x-3</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>12 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berwick</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The Clinical Center, Bethesda 14, Md.</u>				d. STREET ADDRESS <u>R. D. 1</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Cynthia</u> Middle <u>Maxine</u> Last <u>Zehner</u>				4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29, 1954</u>		9. AGE (In years lost birthday) <u>5</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Child</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Vincent Zehner</u>				14. MOTHER'S MAIDEN NAME <u>Mary Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>The Medical Record</u> Address <u>The Clinical Center, Bethesda 14, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>(Brain Positive Cocci) Septicemia</u> <u>204.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Lymphatic Leukemia</u> DUE TO (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 10, 1959</u> to <u>June 22, 1959</u> , that I last saw the deceased alive on <u>June 22, 1959</u> , and that death occurred at <u>6:10 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Nathan S. Taylor</u>		M.D. <u>The Clinical Center</u>		ADDRESS (Street, city or town, state) <u>National Institutes of Health</u>		DATE SIGNED <u>6-22-59</u>	
PHYSICIAN'S NAME (Type) <u>Nathan S. Taylor, M. D.</u>				<u>Bethesda 14, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Berwick, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u>				ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>JUN 24 59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

2

050

75x-3

CERTIFICATE OF DEATH

1. Name of deceased: *John Edward Smith*

2. Sex: *Male*

3. Age: *45*

4. Date of death: *Jan 15 1910*

5. Place of death: *Home*

6. Cause of death: *Myocardial Infarction*

7. Signature of physician: *Dr. J. H. Jones*

8. Signature of registrar: *Wm. A. Smith*

9. Date of registration: *Jan 16 1910*

10. Place of registration: *Boston*

7048

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>56 SILVER SPRING</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>1708 REPUBLIC ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>MELVIN</b> Last <b>ZINS</b>		4. DATE OF DEATH Month <b>JUNE</b> Day <b>15</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 16, 1950</b>
9. AGE (In years last birthday) <b>9</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STUDENT</b>	11. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>LESTER ZINS</b>	
14. MOTHER'S MAIDEN NAME <b>LILLIAN RINBERG</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>NO</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>LESTER ZINS - 1708 REPUBLIC RD., SIL. SPG. MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>754.5 Congenital heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Birth to present</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ <b>19</b>	20d. INJURY OCCURRED While o. m. _____ Not while o. m. _____ <input type="checkbox"/> <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>birth</b> , 19____, to <b>6/15</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>6/15</b> , 19 <b>59</b> , and that death occurred at <b>5:00 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>8301 Piney Branch Rd Silver Spring, Md</b> DATE SIGNED _____			
ACTUAL SIGNATURE <b>Herbert D. Glick</b>		M.D. <b>8301 Piney Branch Rd</b>	
PHYSICIAN'S NAME (Type) <b>HERBERT D. GLICK, M.D.</b>		ADDRESS <b>Silver Spring, Md</b>	
22a. BURIAL, CREMATION, or other disposition (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>6-17-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>HYATTSVILLE, MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. DANZANSKY &amp; SONS- 3501 14th STREET, N.W.</b>		24a. REC'D BY REGISTRAR <b>JUN 19 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and is hereby filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1907

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		45		Jan 15, 1907		New York City	
Cause of Death		Disease		Symptoms		Time of Death		Physician	
Heart Disease		Myocarditis		Chest pain, shortness of breath		10:30 AM		Dr. J. Smith	
Burial Place		Funeral Home		Burial Date		Burial Time		Burial Place	
St. John's Church		123 Main St		Jan 18, 1907		11:00 AM		St. John's Church	
Signature of Registrar		Signature of Physician		Signature of Burial Officer		Signature of Witness		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	